VERMONT STATE PLAN ON AGING
for
Federal Fiscal Years 2007 - 2010

October 1, 2006 through September 30, 2010

AS REQUIRED BY
THE OLDER AMERICANS ACT OF 1965,
AS AMENDED THROUGH 2000

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July, 2006

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This State Plan on Aging can also be found on our website:

www.dail.state.vt.us

VERIFICATION OF INTENT

The State Plan on Aging is hereby submitted for the State of Vermont for the four-year period October 1, 2006 through September 30, 2010.

The plan includes assurances and plans to be conducted by the Vermont Department of Disabilities, Aging and Independent Living under provisions of the Older Americans Act, as amended, during the period specified. The State Agency named above has been given the authority to develop and administer the State Plan on Aging in accordance with all of the State activities related to the purposes of the Act, including the development of comprehensive and coordinated systems for the delivery of supportive services, such as multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for the older adults and family caregivers in the state.

This plan is hereby approved by the Secretary of the Agency of Human Services, designee of the Governor, and constitutes authorization to proceed with activities under the Plan upon approval by the U.S. Assistant Secretary on Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.

(Signed) _____ (Date) _____

Patrick Food, Commissioner
Department of Disabilities, Aging and
Independent Living
State of Vermont

TABLE OF CONTENTS

TOPIC	PAGE
Guide to State Plan on Aging Acronyms	1
Purpose of the State Plan On Aging	3
Mission Statement	4
Vermont's Older Population	7
• Demographics of Vermont's Aging Population	7
• Health Care Issues	12
• Family Caregiving	17
• Independent Living And Community-Based Services	19
• Transportation	22
• Living Arrangements	23
• Volunteer and Other Opportunities to Support Successful Aging and Independent Living	25
• Employment	26
Needs, Issues and Concerns of Older Vermonters	27
• Consumer Direction and Independent Living	27
• Role Of Senior Centers and Community Nutrition Programs	29
• Health Care	29
• Workforce Issues	30
• Economic Security	31
Goals, Objectives and Program Resources for Federal Fiscal Year 2007 to 2010	33
• Goals and Outcomes	33
• Resources	36
• Special Projects and Initiatives	39
• Programs Funded Under the OAA	50
o Title III Services	50
o Title VII Services	58
• Programs Funded with other Resources	64
Summary of Public Hearing and Comments	78
Method of Distribution for Title III and State Funding	79
Population Data and 'Old, Alone and Poor' Data for Selected AAA Service Area by Elderly Age Groups	80
Older Americans Act Allocations to Area Agencies on Aging	81
State Agency and Area Agency Information	83
Assurances	84
Endnotes	94

GUIDE TO STATE PLAN ON AGING ACRONYMS

Acronym	Description
AAA	Area Agency on Aging
ADDGS	Alzheimer's Disease Demonstration Grants to States Program
ADP	Adult Day Program
ADRC	Aging And Disability Resource Center
ADRD	Alzheimer's Disease and Related Disorders
AHS	Vermont Agency of Human Services
AoA	Administration on Aging
APS	Adult Protective Services
ASP	Attendant Services Program
BISHCA	Vermont Department Of Banking, Securities and Health Care Administration
BJBC	Better Jobs/Better Care
BRFSS	Behavioral Risk Factor Surveillance System
CFC	Choices for Care
CMHC	Community Mental Health Center
CLTCC	Champlain Long Term Care Coalition
CMS	Centers For Medicare and Medicaid Services
COASEV	Council on Aging for Southeastern Vermont
COVE	Community of Vermont Elders
CVAA	Champlain Valley Agency on Aging
CVCOA	Central Vermont Council on Aging
DAIL	Department of Disabilities, Aging and Independent Living
DDAS	Division of Disability and Aging Services
DMH	Division of Mental Health
ECC	Elder Care Clinician
ECCP	Elder Care Clinician Program
ERC	Enhanced Residential Care
FCS	Family Caregiver Support
FSCPE	Federal/State Cooperative Program for Population Estimates
FGP	Foster Grandparent Program
HASS	Housing and Supportive Services
HCB	Home- and Community-Based
HHA	Home Health Agency
I&A	Information and Assistance
I/R/A	Information/Referral/Assistance
MMA	Medicare Modernization Act
N2N	Neighbor to Neighbor AmeriCorps Program
NEVAAA	Northeastern Vermont Area Agency On Aging
NFCSP	National Family Caregiver Support Program
NSIP	Nutrition Services Incentive Program
OAA	Older Americans Act
OAP	Old, Alone and Poor
OPG	Office of Public Guardian

Acronym	Description
OVHA	Office of Vermont Health Access
PACE	Program for All-Inclusive Care for The Elderly
RLTCC	Rutland Long Term Care Coalition
SAMS	Social Assistance and Management Systems
SCLP	Senior Citizens Law Project
SCP	Senior Companion Program
SCSEP	Senior Community Service Employment Program
SHIP	State Health Insurance Assistance Program
SMPP	Senior Medicare Patrol Project
SVCOA	Southwestern Vermont Council On Aging
TBI	Traumatic Brain Injury
VAHHA	Vermont Assembly of Home Health Agencies
VAPCP	Vermont Association of Professional Care Providers
VCIL	Vermont Center for Independent Living
VDH	Vermont Department of Health
VOP	Vermont Ombudsman Project
VPTA	Vermont Public Transportation Association
VTrans	Vermont Agency of Transportation

PURPOSE OF THE STATE PLAN ON AGING

In order to plan for the ongoing and future needs of older adults in Vermont and to meet the requirements of Section 307 of the Older Americans Act (OAA), the Department of Disabilities, Aging and Independent Living (DAIL), the designated State Unit on Aging for Vermont, has prepared a State Plan for submission to the federal Administration on Aging (AoA). Vermont has opted to present a Four-Year State Plan for the period October 1, 2006 through September 30, 2010.

The State is required by regulation to:

a) Develop a State Plan for submission to the Assistant Secretary on Aging;
b) Administer the State Plan in accordance with Title III of the OAA, as amended;
c) Be responsible for planning, policy development, administration, coordination, priority setting and evaluation of all state activities related to the objectives of the OAA;
d) Serve as an effective and visible advocate for older individuals by reviewing, commenting on and recommending appropriate action for all State plans, budgets and policies which may impact older Vermonters; and,
e) Provide technical assistance and training to any agency, organization, association or individual representing the needs and interests of older individuals.

This plan reflects the Agency of Human Services' vision that Vermonters are healthy, safe and achieve their greatest potential for well-being and personal independence in healthy, safe and supportive communities as well as the Department's commitment to increasing investments in community-based systems of long-term services and supports, to increasing consumer flexibility and choice and ensuring that older adults and individuals with disabilities have easy access to well-coordinated and effective services that promote healthy aging and independent living. In addition, the State Plan incorporates the broader vision and goals of the Department into the body of the plan and includes feedback received during the public hearing and comment period.

Finally, the State Plan describes the values, available resources, goals and strategies designed to achieve Departmental goals and as such offers a framework for the ongoing operations of programs funded through the Older Americans Act.

MISSION STATEMENT

The Department of Disabilities, Aging and Independent Living's mission is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.

To achieve this goal, the Department is committed to fostering the development of a comprehensive and coordinated approach to the provision of community-based systems of services for older adults and people with disabilities. Our goal is to enhance the ability of these Vermonters to live as independently as possible, actively participating in and contributing to their communities. As we approach this work, we are guided by the following core principles:

- ***Person-centered:*** the individual is at the core of all plans and services.
- ***Respect:*** individuals, families, providers and staff are treated with respect.
- ***Independence:*** the individual's personal and economic independence are promoted.
- ***Choice:*** individuals will have options for services and supports.
- ***Self-determination:*** individuals direct their own lives.
- ***Living well:*** the individual's services and supports promote health and well-being.
- ***Contributing to the community:*** individuals are able to work, volunteer and participate in local communities.
- ***Flexibility:*** individual needs guide our actions.
- ***Effective and efficient:*** individuals' needs are met in a timely and cost effective way.
- ***Collaboration:*** individuals benefit from our partnership with families, communities, providers, and other federal, state and local organizations.

We are proud of Vermont's history of constantly re-evaluating the system of aging and long-term services and supports and in developing innovative approaches to using our limited resources to respond to the needs and preferences of Vermont's aging population. In 1996, the Vermont State Legislature passed Act 160, landmark legislation intended to "shift the balance" of resources from nursing facilities to community-based services. The implementation of Act 160 resulted in the first major expansion of community-based services so that Vermonters had more choices and options to receive the care and services needed to remain in their own homes and communities than had before. After many years of planning, in October, 2005 the Department implemented a new 1115 Long Term Care Medicaid Waiver, Choices for Care. This research and demonstration waiver will allow the State to expand Medicaid Long Term Care entitlement to individuals who are seeking home and community-based services and to demonstrate that by providing preventive services to those not yet clinically or financially eligible for Medicaid Long Term Care, that the need for more costly services can be delayed or prevented. This State Plan represents the next phase of our efforts to promote the development of an easily accessible and comprehensive system of services, driven by consumers and their families, that promotes the greatest degree of independence.

Our mission must include the work of the Area Agencies on Aging (AAAs) and other community partners to provide services which prevent poverty, isolation, poor health and institutionalization. We are committed to assisting communities in identifying prevention models and in working with other state agencies and our community partners to explore new

approaches to managing chronic conditions and promoting healthy aging We will assist in planning for, supporting and implementing community-based programs, services and initiatives which offer front line support to assist older adults in retaining their maximum level of independence, because we recognize this is an essential component for successful aging and independent living. We also recognize and strive to support the contributions of family caregivers, since without them many Vermonters would be at great risk of losing independence and the key social connections that result in a high quality of life.

The Department will conduct the following activities under the State Plan on Aging:

- Help communities plan for the needs of an aging population and provide for a comprehensive and coordinated system of services for older adults and family caregivers;
- Advocate for their rights, benefits and service needs, with the assistance of public and private resources and organizations whose services and activities make a difference in the well-being of older adults and family caregivers;
- Identify older adults and family caregivers who are eligible for assistance under the OAA, and inform older adults, family caregivers and the general public of the services available to meet their needs;
- Recognize and correct any gaps in the ability to identify or provide services to meet these needs;
- Forge collaborative partnerships with families, communities, providers, and other federal, state and local organizations in order to fill the gaps that exist for meeting the needs of older adults and family caregivers;
- Develop or support the development of a variety of services and systems of care which may be funded through grants, contracts or community contributions, including those which focus on evidence-based prevention initiatives;
- Designate Area Agencies on Aging for the purpose of carrying out the mission of the OAA;
- Evaluate these agencies to ensure that their activities are in keeping with the OAA and the mission of the Department; and
- Ensure that resources made available to the Area Agencies on Aging under the Older Americans Act are used to carry out the mission of the Act as it is described in applicable law, regulation and State Agency policy.

As described in Section 305 of the Act, the Department will target services to older adults who:

- Are in greatest economic and social need;
- Are at greatest risk of loss of independence due to frailty, severe disabilities and/or chronic conditions;
- Reside in rural areas;
- Have Alzheimer's Disease or a related disorder and the caregivers of those individuals; and/or,
- Are older low-income minority individuals.

While we are dedicated to providing services to those in greatest need, a significant percentage of Vermont's older adults may not fit into one or more of the specific target groups noted above.

The five AAAs provide assistance to many older adults and family caregivers who have short term needs, or require help which is intermittent in nature. In fact, thousands of older adults are able to retain their independence because of ongoing case management, nutrition services and other OAA services that are not crisis driven, but are more preventive in nature. In recent years, much emphasis has been placed on promoting the availability of evidence-based disease prevention and health promotion activities that lead to a healthier, more fulfilling life. Without such assistance many would eventually be at greater risk for deteriorating health and/or economic status, either of which can lead to a loss of independence. In addition, many consumers of AAA services regain their independence after a stay in a hospital or nursing facility, as a result of case management support, nutrition services and other interventions.

Vermont's Department of Disabilities, Aging and Independent Living is the sole state agency responsible for the administration of the State Plan on Aging. As described within the Older Americans Act, Title III, Section 301, and Section 1321.7 of the Rules and Regulations the Department must:

- Develop greater capacity and foster the development of comprehensive and coordinated systems which secure and maintain maximum independence and dignity in a home environment for older adults capable of self-care, with appropriate supportive services;
- Remove individual and social barriers to economic and personal independence for older adults;
- Provide a continuum of care for vulnerable older adults; and,
- Secure the opportunity for older adults to receive in-home and community-based long-term care services and supports.

VERMONT'S OLDER POPULATION

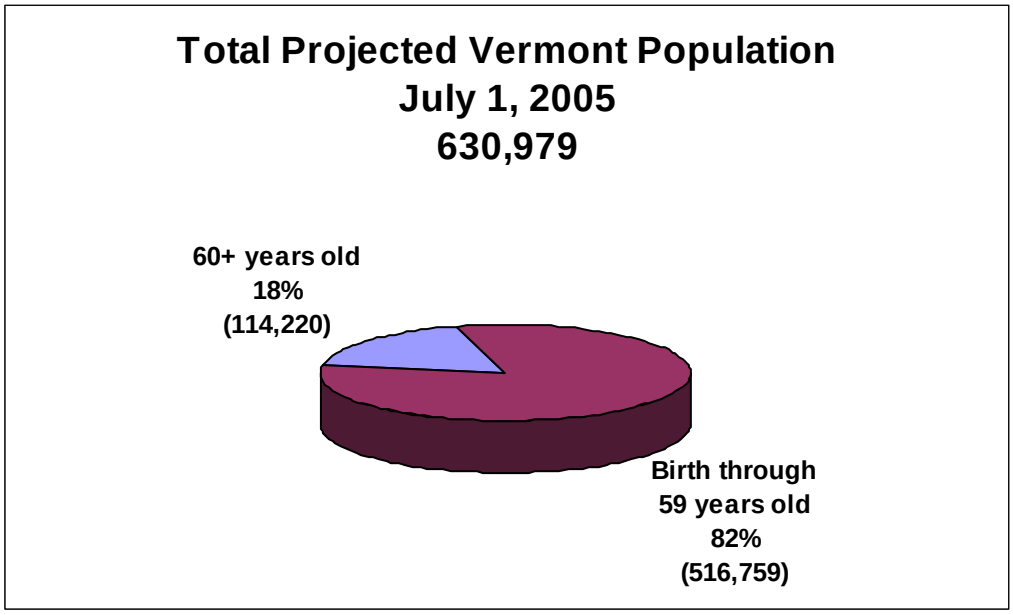
The population of the United States is aging, a fact of which we are well aware. In 2000, the U.S. Census Bureau estimated the number of older adults (those 65+) at 35 million, or 12.4% of the total population. Current projections show this number growing to 54 million or 16.5% by 2020. By 2030, 20% of all Americans will be an older adult. In addition, we are living longer -- much longer than previous generations. Today, the average life span for a woman is 80; for a man it is 75.[i] This is 28 years longer than the average life expectancy was in 1900.

Vermont's population is older than average, and will continue to age in the coming decades.

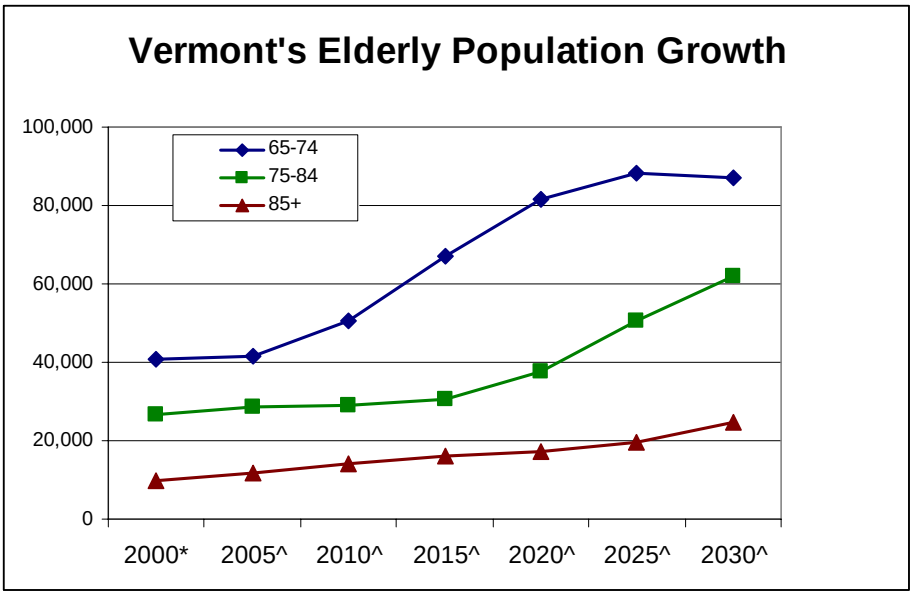
Demographics of Vermont's Aging Population

Population Trends[ii]

- The number of Vermonters over the age of 60 grew from 88,432 in 1990 to 101,827 in 2000, an increase of 13,395 or 15.15%. According to current projections there will be 114,220 Vermonters over age 60 in 2005, an increase of 12,393 people or 12.17%.

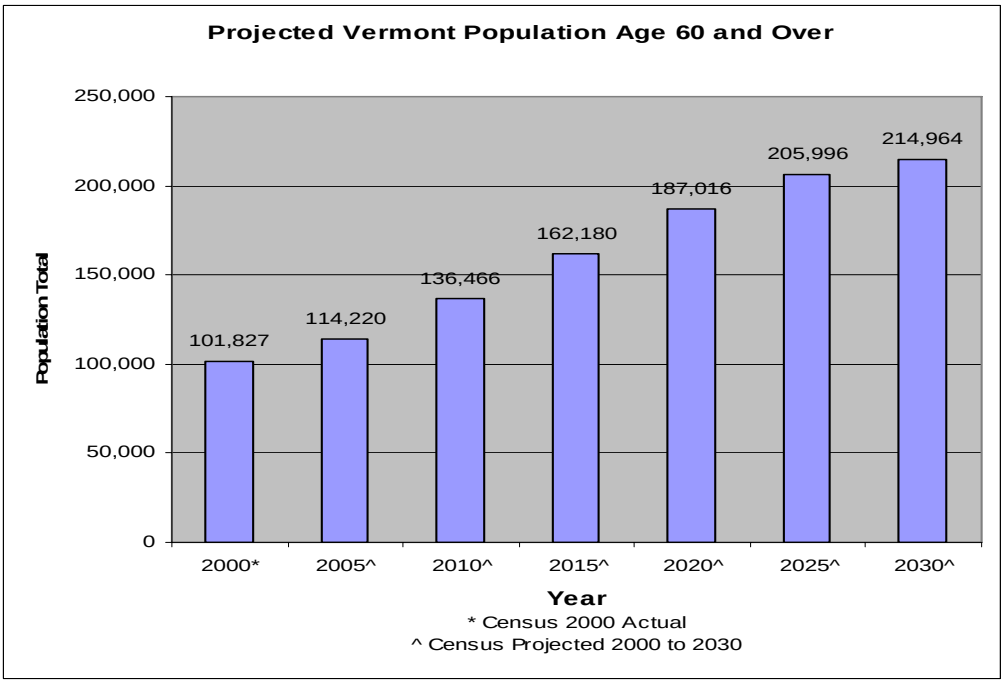


^ Projected Population Growth from US Census Table 6: Interim Projections: Total Population for Regions, Divisions, and States: 2000 to 2030



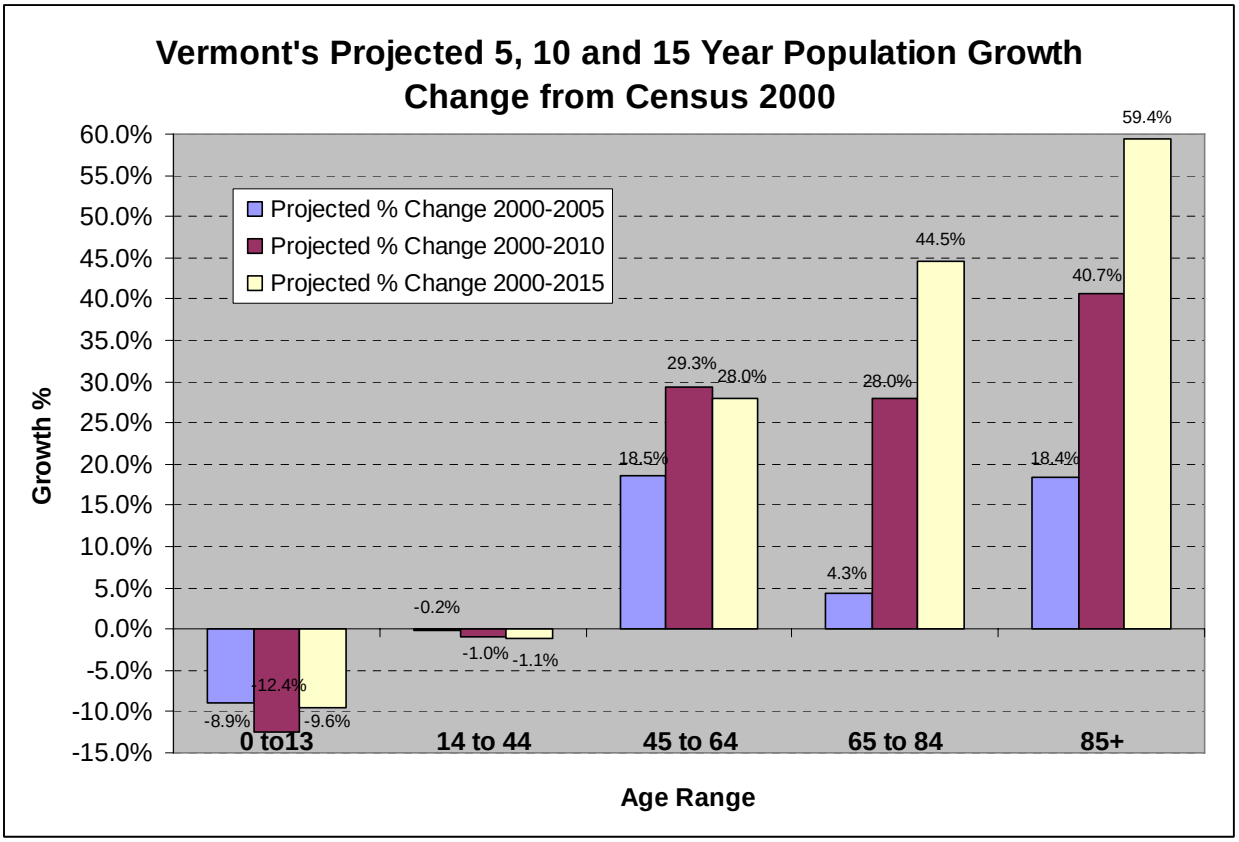
***** US Census 2000 Total Population from Summary File (SF 1) 100-Percent Data
^ Projected Population Growth from US Census Table 6: Interim Projections: Total Population for Regions, Divisions, and States: 2000 to 2030

- We anticipate a significant increase in Vermonters age 65-74 by 2015. Growth in the numbers of people age 60+ will continue through 2030.



Projected Population Growth from US Census Table 6: Interim Projections: Total Population for Regions, Divisions, and States: 2000 to 2030

- The population age 75 and older is projected to grow from 47.5% of the total population over age 65 in 2000 to 49% in 2005.
- Between 2000 and 2005, the number of 'old old', those age 85 and older, increased from 9.8% to a projected 10.3% of the over 60 population.
- The 45 to 64 year old age group is currently the fastest growing segment of Vermont's population, with a projected growth rate of 18.5% between 2000 and 2005. The population of children age 0 to 13 declined by 8.9% during the same period.
- At current growth rates, by 2010 the 45 to 64 year old age group will no longer be the fastest growing segment of Vermont's population. The 65 to 84 age group will be the fastest growing segment. During this same period the population of children age 0 to 13 is expected to show a further decline from 8.9% to 12.4%.
- Projections for 2015 show that the 85+ age group will take the lead as the fastest growing segment of the population. The number of children aged 0 to 13 will increase slightly, but with an overall decline of 9.6% from the 2000 baseline.

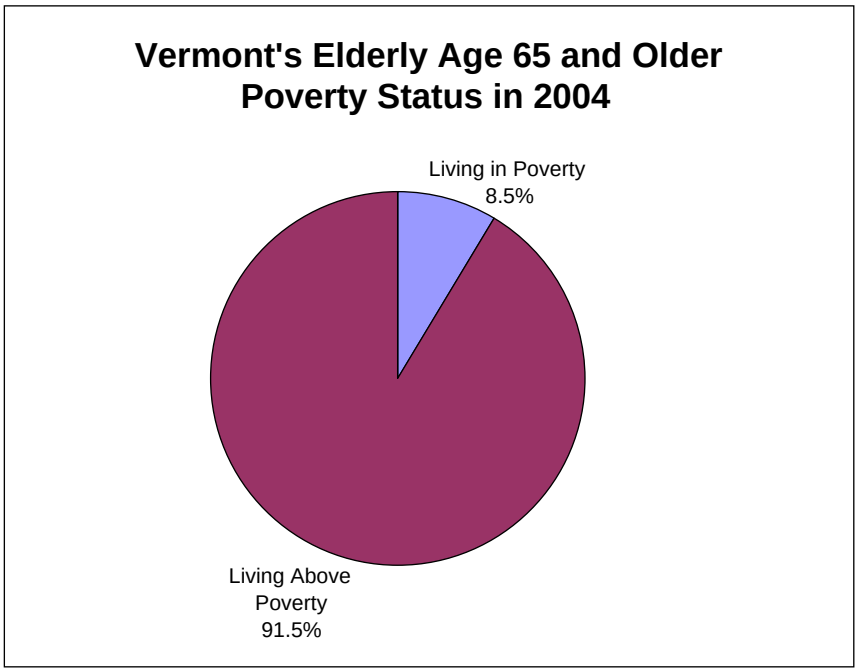


Rurality

- For the purpose of this State Plan on Aging, the entire State of Vermont is considered to meet the federal definition of "rural." Rural older adults are more likely to live at or near poverty than those in metropolitan regions. While nationally 11 percent of non-metro older adults were poor as compared to 10 percent of metro older adults, 17.2 percent of non-metro older adults are living near poverty level, as compared to 13.5 percent of metro older adults.[iii]
- Non-metro older adults are less educated and reported themselves to be in poorer health than older adults living in metropolitan settings.[iv] They are more likely to own their own homes; however, the value of their homes is less than homes in urban areas.[v]
- The rural housing for older adults that is available is generally in poorer condition including problems with plumbing, heating, electricity and in need of maintenance than that in metro areas.[vi]
- Older adults living in rural areas have less access to health care, including specialized health care, and these services tend to be more costly than those provided in metropolitan areas. Rural older adults usually have to travel farther to access these key resources, and yet at the same time, they have less access to transportation. Because of this, many rural older adults have unmet needs.[vii]
- Based on our projections 10,301 rural older Vermonters over the age of 60 are living below 125% of poverty. This represents a .7% increase from 2002 (10,230). (NOTE: Refer to the state funding formula and Old, Alone and Poor detail later in this document.)
- In keeping with the requirements of the OAA, the State will spend at least as much as what was spent in Federal Fiscal Year 2000 on services to older Vermonters residing in rural areas.

Poverty

- 2004 Census estimated data showed that 8.5% of Vermonters age 65 or older lived at or below 100% of poverty.



- Many older adults' incomes are only slightly above the federal poverty level. According to a 2003 survey conducted by the Bureau of Labor Statistics, in older households 33.1% of their expenditures were spent on housing, 16.4% on transportation, 13.3% on food and 12.7% on health care.[viii] An analysis of spending between 1984-1997 found that spending by older consumers increased significantly, by 14% – 18% and that spending for health care by older adults comprised almost one third of all health care spending nationwide, with notable increases in spending for health insurance and medications. These expenses bring many close to or below the federally defined poverty threshold. [ix]
- The risk of poverty is strongly related to one's living arrangement, with 18.6% of older adults who live alone poor, as compared to 5.8% of those who live with families. In addition, older women are more likely to live in poverty (12.5%) than older men (7.3%). [x]

Minority Elderly

- Vermont continues to have one of the lowest percentages of older minorities in the nation, according to the 2000 Census. It represents a mere 1.7 percent of the total population age 60 or older.
- The 2000 Census reports 1,738 people were identified as age 60 or older and members of a minority group, which represents a 253% increase from the 492

minority older adults reported in the1990 census. Of these, 28% were age 75 or older. However, the Census minority data from 1990 – 2000 may not be directly comparable because of changes in the survey questions regarding race.

- The greatest proportion of the minority population can be found in Chittenden County. Of the state's 19,619 minority population, 7,125, or 36.3% reside in Chittenden County. The majority of Vermont's minority older adults also reside in Chittenden County (n = 456, or 26.2%).
- One hundred ninety-five older Vermonters were identified in the 2000 Census as Native Americans. This comprises only 0.2% of older adults age 60 and older in Vermont. According to the 1999 Population and Housing Estimates published by the Vermont Department of Health, the highest concentration of people who identify themselves as Native Americans are found in Franklin County.[xi]
- In May 2006, Vermont Governor James Douglas signed a bill giving Vermont's Abenaki population formal state recognition.[xii] However, Vermont's Abenaki population does not receive tribal aid because they lack federal designation as Native Americans. This increases the risk that older Abenakis, compared to other minorities, are likely to live at or below poverty.[xiii]

Health Care Issues

Mirroring national trends, Vermont's demographic landscape is undergoing a significant shift, whereby the percentage of the population older than 60 years is growing more rapidly than younger age groups. Aside from the impact on individual health and well-being, this trend has implications for many systems: health care delivery; social support networks; housing; and transportation. Concurrent with this demographic trend is a change in the causes of death from infectious to chronic diseases. Improvements in health and quality of life can be achieved by practicing healthful behaviors, screening for and identifying chronic conditions and disease, modifying health risks and managing chronic conditions. The Department continues to support initiatives that will achieve that end through involvement with multiple statewide initiatives including the Governor's Commission on Healthy Aging, the Vermont Blueprint for Health, and community-based grass roots efforts often associated with the AAAs.

In 2005, a new Governor's Commission on Healthy Aging was convened. Chaired by the Lieutenant Governor, the Commission is carrying on the efforts begun by the Successful Aging and Independent Living (SAIL) Task Force. The role of the Commission is to:

- Help prepare our state for the changing demographics and increase in percentage of people over the age of 65.
- Build a community of individuals and groups with an awareness of how our state will be impacted by this shift in demographics.
- Build upon best ideas and best practices.
- Guide legislation.
- Impact the landscape by influencing budgets that are responsive to aging issues.

Part of Governor James Douglas' Prescription for a Healthy Vermont, the Vermont Blueprint for Health is "a statewide initiative that provides Vermonters with chronic conditions the information, tools and support they need to successfully manage their health".[xiv] Led by the Vermont Department of Health (VDH), the Blueprint is based on the chronic care model; and Department staff participates in three of the Blueprint workgroups: Healthy Communities, Self-Management, and Health Systems; as well as membership on the Steering Committee.

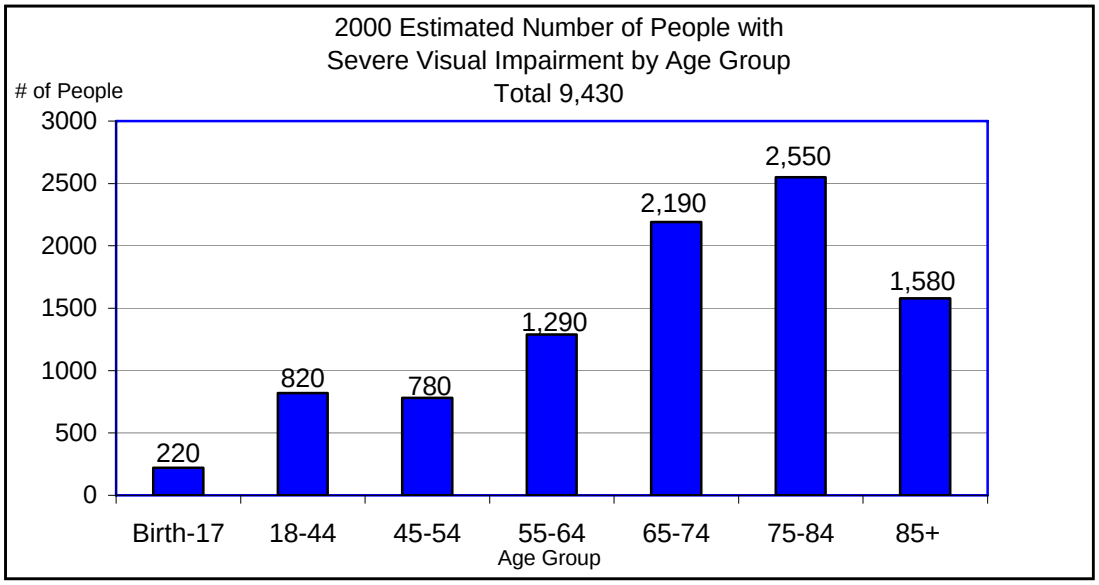
Indicators of Health and Disability Status

- As noted earlier, the average lifespan of Vermonters is increasing. In addition, recent national surveys show a reduction in disability in the older population. [xv] However, the older population is at greater risk for arthritis, osteoporosis and other physical disabilities.[xvi]
- Although older adults in Vermont are vaccinated against pneumonia and influenza at higher rates than in most other states (66% and 75%, respectively; resulting in a national ranking of 11th and 8th highest levels)[xvii], these infectious diseases remain a leading cause of hospitalization among this age group.
- In 2004, Medicare paid for 16.5% of Vermont's total health care expenditures, Medicaid paid 25.8% and private insurance paid for 39.5% of Vermont health care expenditures. These percentages have remained relatively steady with only slight fluctuations since 2000. [xviii]
- Data from the 2002 Vermont Behavioral Risk Factor Surveillance System (BRFSS) Survey indicate that 61% of older Vermonters are overweight or obese[xix]; (19% are obese)[xx] [based on body mass index (BMI) calculations from self-reported height and weight] up from 49% in 1992. Despite the well-known benefits of healthy weight and weight management on chronic disease burden and functionality, only 20% of overweight or obese older adults report being advised by their physician to lose weight.[xxi]
- On the whole, too few older Vermonters participate in regular physical activity; this has implications for their physical, emotional and mental health. In 2002, 32% report not participating in any leisure physical activity within the past month.[xxii] The most recent data on older adults engaging in physical activity for 30 minutes daily at least five days per week is similarly low; in 2000 less than 25% reported that level.[xxiii] The *Healthy Vermonters 2010* target for regular physical activity is 30% of adults.[xxiv]
- While there is still opportunity for improvement in participation by older Vermonters in regular physical activity, there has been tremendous growth in health promotion programs for older Vermonters, such as the Tufts Strong Living and Bone Builders programs.
- The two leading cases of death in Vermont are heart disease and cancer, followed by stroke, chronic obstructive pulmonary disease (COPD), and unintentional injuries.[xxv]
- Among older adults, the most prevalent chronic conditions are heart disease, diabetes, hypertension, cancer, stroke, and arthritis.[xxvi]
- Diabetes is the 6th leading cause of death among older Vermonters; and while treatable and highly responsive to self-management intervention, is also the major cause of limb amputations, blindness and kidney disease.[xxvii] The prevalence of

diagnosed diabetes among older adults has risen from 11.2% in 2000 to 13.6% in 2005.[xxviii]

- The leading cause of injury-related hospitalizations among older adults is falls. In 2002, 13% and 12% of older women and men, respectively, reported falling to the ground within the last year.[xxix]
- Falls are the leading cause of death from unintentional injury among older Vermonters.[xxx]
- The majority of older adults that suffer a hip fracture do not regain their pre-fracture level of independence; and the one year mortality rate associated with hip fracture is approximately 24%. Based on CDC estimates, 2,464 individuals in Vermont will experience a hip fracture over a five-year period. In 2002, 14% of older Vermonters reported being told by their physician that they have osteoporosis.[xxxi] Utilizing available treatments may reduce fracture events by 50%.[xxxii]
- Of the 10,722 individuals participating in the OAA Nutrition Program in Federal Fiscal Year 2005 (3,925 home delivered meal recipients; 6,797 community meal site participants); 30.5% (n=1,199) of the home delivered meals clients were at high risk for malnutrition, and 13.7% (n=936) of the community meals clients were at similar risk. The latter figure is likely an underestimate due to incomplete reporting.
- Participation at Vermont's OAA Act Nutrition Program community meal sites is declining. These sites, often co-located with a community senior center, represent an important source of health promotion and disease prevention services and programs, socialization and volunteer opportunities, and information/referral services. Vermont's efforts to boost participation at senior centers and community meal sites are described in the *Special Projects and Initiatives – Senior Center Federal Funding* section of this State Plan on Aging.
- Diets rich in fruits and vegetables may reduce the risk for certain cancers and other chronic conditions such as diabetes and cardiovascular disease. Only 35% of older Vermonters report at least five servings of fruit and vegetables daily[xxxiii], well below the *Healthy Vermonters 2010* target of 75% eating at least two servings daily of fruit and 50% eating at least three servings daily of vegetables.[xxxiv]
- Hunger and food insecurity increases the risk for malnutrition; contributing to a greater incidence of infection, increased surgical risk, longer healing time and hospitalization, and increased risk of complications. The number of older Vermonters being served by emergency food shelves and community kitchens has risen steadily since 1996. In 2003, 23% of Vermont households who visited a food shelf included an older adult; and 24% of meals served in community kitchens were eaten by older adults.[xxxv]
- As the Baby Boomer generation ages, more and more people will be at risk for age-related eye diseases, such as macular degeneration, cataract, diabetic retinopathy and glaucoma. Prevent Blindness America estimates that nationally the number of people with age-related eye disease and vision impairment will double within the next three decades.[xxxvi] Already, an estimated 21% of Vermonters age 65 and older report vision problems.[xxxvii]
- Older Vermonters take multiple medications for their chronic conditions, carrying the risk of unpleasant and harmful side effects in addition to adverse drug interactions.

BRFSS data from 2002 suggest that nearly half of older adults take three or more prescription or over-the-counter medications daily. [xxxviii]



Information provided by the Department's Division for the Blind and Visually Impaired.

Mental Health and Substance Abuse

- The U.S. Surgeon General predicts that because of the expected growth in the older population, disability due to mental illness in older adults will become a major public health problem in the near future. Dementia, depression and schizophrenia will pose particular challenges.[xxxix]
- An estimated one million adults age 65 and older suffer from major depression and an additional 5 million have depressive symptoms severe enough to require treatment.[xl] In nursing facilities, it is estimated that major depression increases the likelihood of mortality by 59 percent, independent of any physical health issues.[xli]
- Depression frequently co-occurs with other chronic illnesses such as heart disease, diabetes and cancer, and it is often assumed that depression is a normal consequence of these health problems. As a result, depression is often undiagnosed and untreated in older adults.[xlii]
- Major depression is a predictor of suicide in older adults and, in older white males suicide occurs at a rate six times that of the general population.[xliii]
- Studies show that many older adults who die by suicide visited a primary care physician within a very short time of their death; 20 percent on the same day, 40 percent within one week and 70 percent within one month.[xliv]
- In Vermont, males 65 years of age or older have the highest rate of suicide, occurring at a rate of 22 for every 100,000 individuals. This compares to a national rate of 15.6 per 100,000 individuals.[xlv] Risk factors for suicide in older adults are different than those for younger persons and include depression, chronic medical conditions, lack of social supports and divorce or widowhood, all common experiences for many older adults who live alone, in impoverished circumstances.[xlvi]

- Although schizophrenia affects a very small proportion of the older population (0.6%), the cost of mental health treatment for this disease is significantly higher than for other mental illnesses.[xlvii]
- The Center for Substance Abuse Treatment reports that the nation's older adults primarily experience problems related to the abuse or misuse of alcohol and/or prescription drugs. Nationally, the prevalence of heavy drinking (12 – 21 drinks per week) in older adults is estimated at 3 - 9%. One-month prevalence estimates of alcohol abuse and dependence in this group are much lower, ranging from 0.9 percent to 2.2 percent. Overall, alcohol abuse and dependence are approximately four times more common among men than women age 65 and older.[xlviii]
- In 2005, six percent of adults age 60 and older who received services through the Elder Care Clinician Program had a primary or secondary diagnosis of substance abuse.[xlix]
- According to the Center for Substance Abuse Treatment, alcohol abuse in older adults is often undetected or is sometimes mistaken for other diseases. The Center cites ageism, lack of awareness of the problem; clinician behavior; and medical and psychiatric co-morbidity as the key barriers to treating older adults with substance abuse problems. [l]

Cognitive Impairments

- Mild cognitive impairment (MCI) is a general term most commonly used to describe a subtle but measurable memory disorder. By this definition, a person with MCI has memory problems greater than normally expected with aging, but does not show other symptoms of dementia, such as impaired judgment or reasoning. Some research suggests that nearly all cases of MCI eventually progress to Alzheimer's Disease or another form of dementia. [li]
- Alzheimer's Disease is the most common type of dementia and the 8th leading cause of death in the U.S. According to the National Alzheimer's Association, one in ten people over age 65 and nearly half of those over age 85 have Alzheimer's Disease. Although Alzheimer's Disease is not a normal part of aging, age is the greatest risk factor for acquiring the disease.[lii]
- The incidence of Alzheimer's Disease and Related Disorders continues to grow. Today an estimated 4.5 million Americans have Alzheimer's Disease. This number is projected to reach 5.0 million in 2010 and 7.8 million by 2030. The number of individuals with Alzheimer's Disease could range from 11.3 million to as many as 16 million by the middle of the century unless a way is found to prevent or cure the disease.[liii]
- In Vermont, as of 2006, there are 10,720 diagnosed cases of Alzheimer's Disease. The number of diagnosed cases is expected to increase by 17.5% to 13,000 by 2025. These figures likely underestimate the number of actual cases of the disease.[liv]
- The prevalence of dementia in persons with intellectual disabilities is equivalent to that of the general population. Prevalence rates for adults with Down's syndrome is much higher: 20% among adults age 40 or older and 56% among adults age 60 or older. The onset of Alzheimer's Disease symptoms among individuals with

developmental disabilities and Down's syndrome is earlier than in the general population.[lv]

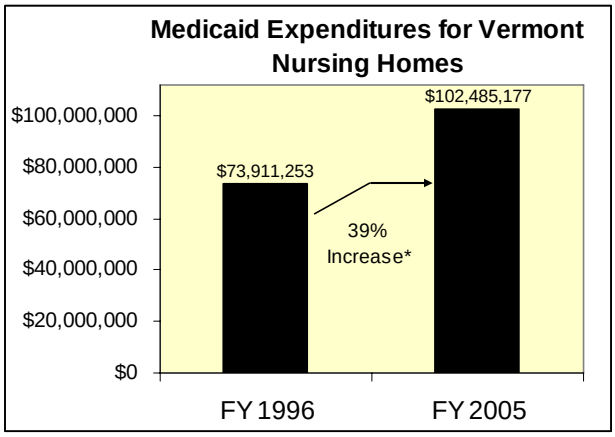
- A recent survey conducted by the Alzheimer's Foundation of America, indicates that concern about stigma associated with Alzheimer's Disease can delay diagnosis by an average of 6 years after symptoms first appear.[lvi] This implies that a significant number of individuals may be at risk for improper treatment or lack of medical/social interventions and support.
- Among those diagnosed with dementia, approximately 24% of those living at home, 24% of residents in assisted living and 27% in nursing facilities have been diagnosed with depression. [lvii]
- The U.S. Surgeon General reports that Alzheimer's Disease, especially when accompanied by behavioral symptoms such as delusions, hallucinations and depression, appears to place individuals at risk for abuse.[lviii]
- More than 70% of those with Alzheimer's Disease live at home and families provide 75% of their care. The remaining 'paid care' costs families an average of $19,000 annually.[lix]
- Nationally, the average cost of nursing facility care for an individual with Alzheimer's Disease is $42,000 per year. The average lifetime cost of care for someone with Alzheimer's Disease is $174,000.[lx]
- Alzheimer's Disease costs American business $61 billion per year. Alzheimer's health care accounts for $24.6 billion of that figure. The remaining $36.5 billion covers costs related to caregivers of individuals with the disease, including lost productivity, absenteeism, and worker replacement.[lxi]
- Total Medicare spending for beneficiaries with Alzheimer's Disease is expected to increase from $62 billion in 2000 to $189 billion by 2015.[lxii]
- State and Federal spending for nursing facility care for individuals with Alzheimer's Disease is projected to increase to $27 billion in 2015, up from $19 billion in 2000. Annual Medicare and Medicaid spending could be reduced by $51 billion and $10 billion, respectively, by 2015 if ways to postpone the onset of Alzheimer's Disease or slowing the progression of the disease were identified.[lxiii]

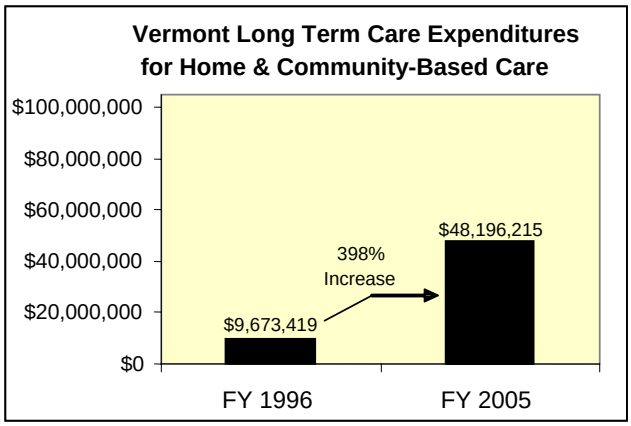
Family Caregiving

- Caregiving provided by family members, friends and neighbors has been described as the "backbone of long-term care." Nearly one out of every four households is involved in caregiving to adults age 50 and older. Unpaid family caregivers will likely continue to be the largest source of long-term care services in the U.S. and are estimated to reach 37 million caregivers by 2050, an increase of 85% from 2000.[lxiv]
- Nearly two thirds of older persons with long-term care needs rely exclusively on family and friends to provide assistance. Another 30% will supplement family care with assistance from paid providers. Care provided by family and friends may determine whether older persons can remain at home. In fact, 50% of older adults who have long-term care needs but no family available to care for them are in nursing facilities, while only 7% who have a family caregiver are in institutional settings. [lxv]

- Nationally, 52 million unpaid caregivers provide care to someone age 20 or older who is ill or disabled, and 8.9 million caregivers care for someone age 50 or older who has dementia.[lxvi]
- An estimated 59%-75% of caregivers are female. Men are involved in caregiving roles more than in the past, but women spend 50% more time providing care than male caregivers. Among caregivers age 75 and older, men and women provide equal amounts of care.[lxvii]
- Older caregivers, many of whom have chronic health problems themselves, make up a significant proportion of caregivers in the U.S. Older caregivers are more likely to be married to the person they are caring for, and tend to care for those who require higher levels of care. Caregivers for individuals with Alzheimer's Disease are more likely to report physical, emotional, family and financial strains than other caregivers.[lxviii]
- In the U.S., adult children provide the bulk of care to adults age 65 and older. As care recipients age, the likelihood of receiving care from a spouse increases.[lxix]
- In Vermont during State Fiscal Year 2005, the pool of caregivers of older adults receiving dementia respite grants was comprised of adult children (40.5%), spouses (42.5%), sons and daughters-in-law (7.3%), grandchildren (1.5%), siblings (2.5%), other family (2.0%) and non-family (3.5%).[lxx]
- Nationally, 50% of family caregivers (including friends and neighbors) provide less than 8 hours of care per week and 20% provide more than 40 hours of care per week. On average, family caregivers provide care for 4.3 years.[lxxi]
- Most family caregivers are employed. Sixty percent of caregivers between the ages of 50 and 64 are working full or part-time. Among employed family caregivers, 66% reduce their work schedules or take unpaid leave to meet their caregiving responsibilities. Such reductions in workforce participation often have long-term financial consequences for the caregiver.[lxxii]
- The estimated economic value of care provided by family caregivers is $257 billion annually, greatly exceeding the cost associated with formal home health care ($32 billion) and nursing facility care ($92 billion) combined.[lxxiii]
- Providing assistance such as counseling, information and on-going support to family caregivers has been shown to help them maintain their caregiving role and delay long-term care placement of individuals with moderate dementia by nearly one year.[lxxiv]
- Recent estimates indicate that 4.18 million grandparents are living with and providing care to their grandchildren. Among those who are the primary caregiver of minor children, 456,000 are age 60 or older.[lxxv].
- More than 2.5 million persons with a developmental disability live with family caregivers, and 26% of the caregivers are age 60 or older.[lxxvi]

Shift the Balance





Independent Living and Community-Based Services

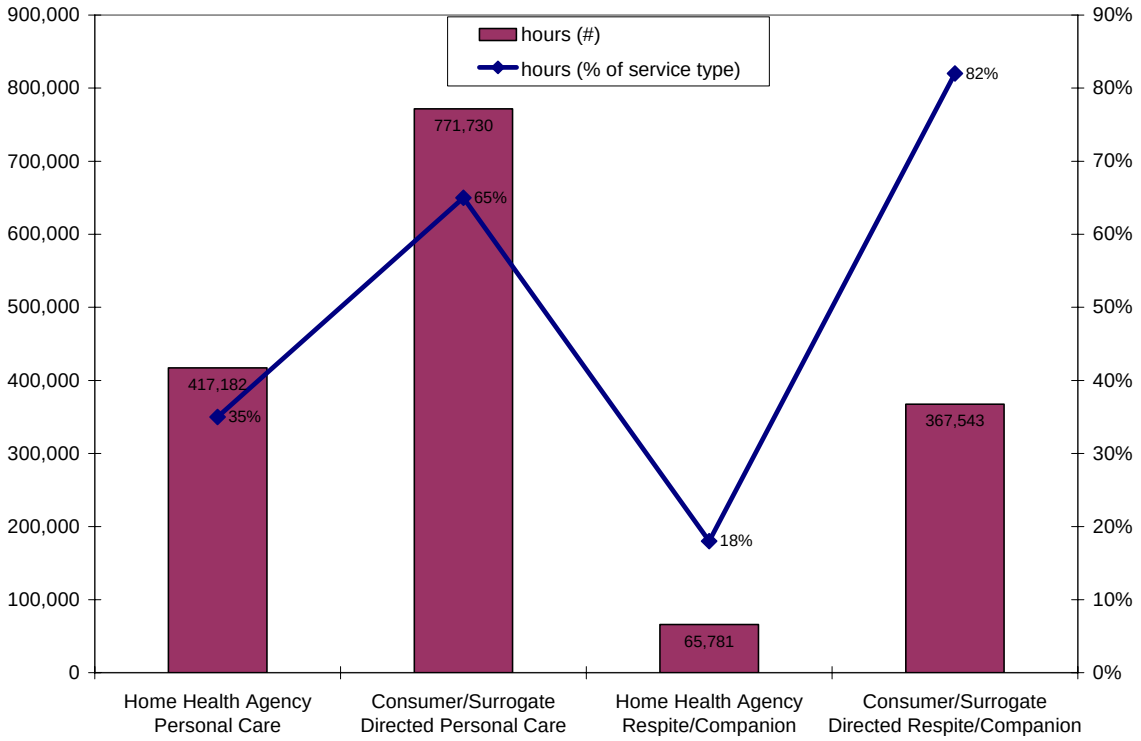
A Snapshot of Expanding Needs

- For many older Vermonters, the State's network of approximately150 senior centers and community meals programs play an important role in promoting successful aging and independent living. Nutritious meals are just one of the services offered at these locations. Over time, many centers have expanded to provide transportation, educational, health and recreational programs. They offer an important opportunity to socialize and maintain connections with the local community; and provide support and reassurance to family caregivers in need of information and respite.
- In State Fiscal Year 2005, the Home and Community Access Program administered by the Vermont Center for Independent Living provided funding assistance to 12 households for 20 projects to help older Vermonters and people with disabilities to remain in their homes by providing technical assistance and funding for home modifications to help them maintain their independence. Typical projects include construction of exterior ramps to improve or create access to and from one's home, and bathroom modifications.[lxxvii]
- Between July 2005 and December 2005, home share services provided by Project Home in Chittenden County and HomeShare of Central Vermont provided support to over 250 individuals seeking a shared housing arrangement. The primary goal of this program is to assist older Vermonters who have a home they want to share with someone seeking a live-in arrangement. For older adults offering their home, reasons vary as to why they seek a shared housing arrangement, but almost always there is some need for a reassuring presence and/or limited assistance with home chores.
- In addition, Project Home in Chittenden County provided support to 149 individuals seeking caregiving matches between older Vermonters and qualified caregivers, often related to the need for help with independent activities of daily living (such as

shopping, housework, laundry), some activities of daily living (such as assistance with bathing or dressing), or related needs.[lxxviii]

- In 2006, the average nursing facility occupancy rate is 90.67%, compared to 89.83% in 2002 when the last State Plan on Aging was written. However, when taking into consideration the fact that over 400 nursing facility beds have closed since the implementation of Act 160 in 1996, the adjusted average nursing facility occupancy rate is closer to 80%.
- In October 2005, Vermont launched Choices for Care, the 1115 Research and Demonstration Program for Long-Term Care. Vermonters who were receiving Long-Term Care Medicaid services at the start of Choices for Care [including nursing facility care, home and community-based services and Enhanced Residential Care (ERC) home services] were automatically included in this program. The Choices for Care program allows eligible individuals to choose the setting in which they will receive their Medicaid Long-Term Care services. The premise is to shift the balance of long-term care expenditures to a less costly environment and serve more people in the setting of their choice.
- Demand for home and community-based services continues to increase. Since implementation of Choices for Care, between October 2005 and March 2006 nursing facility residents decreased by 4.2%, home-based participants increased by 9.5% and ERC usage increased by 19%.
- The Department's approach to "shifting the balance" between nursing facility and home and community-based expenditures is showing results. Between the years 20032 and 2005, total public expenditures in the Department's Medicaid HCBS Waivers grew by approximately 62% while in contrast, Medicaid expenditures in nursing facilities grew by only 13%. [lxxix]
- In Federal Fiscal Year 2005, 69% of the people receiving Choices for Care home-based services were over the age of 60, with an average age of 71.6. In 2005, 94% of the people receiving ERC services were over the age of 60, with an average age of 83.
- According to the Vermont Assembly of Home Health Agencies (VAHHA), Vermont's 12 member home care agencies served fewer people, employed fewer full-time equivalent (FTE) caregivers, and the number of home care visits decreased only slightly between 2000 and 2003. The number of people served declined from 21,726 to 21,375, a 1.6% decrease. Home care visits declined 5.6%, from 920,906 to 869,441. VAHHA reports that these decreases are due to the more restrictive Medicare eligibility requirements and changes in the Medicare reimbursement from fee-for-service to an Interim Payment System. Medicare comprises 50.3% of all home health agency revenues in Vermont, as compared to 31.3% for Medicaid. The remaining 18.4% of revenues come from "other" sources such as private insurance, self-pay, homemaker and town funds. In fact, town funds comprise only 1% of Vermont's home health agency revenues. lxxx
- In the Choices for Care program, 65% of community-based personal care services and 82% of respite and companion services are currently provided through the consumer- or surrogate-directed option.

Waiver/Choices for Care In-Home Services by Type, July 2005-April 2006



- Vermont's five AAAs report an increasing demand for home-delivered meal services**.** In Federal Fiscal Year 2005, the AAAs provided 631,344 meals, nearly a 9.8% increase from the Federal Fiscal Year 2001 level of 574,910. As more of the 'old-old' (age 85+) population ages in place, we anticipate an increase in the population of older adults in Vermont who will need to access this service.
- In Federal Fiscal Year 2005, AAAs provided case management to 8,565 individuals who needed more than Information and Assistance or brief contact assistance. This represents nearly a 5% increase from the Federal Fiscal Year 2001 level of 8,160.
- In State Fiscal Year 2005, Vermont's 14 certified adult day programs operated seventeen sites around the state, and provided 440,852 units of service to 1,027 individuals. This is a 17% increase from the 877 individuals served and a 19.69% increase from the 368,328 units of service provided in 2001. During this same time frame, adult day revenues from Department funded sources grew from $2,411,289 to $3,769,680, a 56.33% increase. Since the last State Plan on Aging was written in 2002, adult day providers have been working very hard to meet the increased demand for their services. Almost every program in the state has been involved in efforts to expand their existing space, establish new satellite locations or build new facilities.

Transportation

- Transportation, whether provided by the older driver, family and friends, or through public transportation or other services, is a key factor in older Vermonters' ability to access needed health care and other services, participate in their communities, connect with families and maintain their independence and well-being.
- Older adults strongly prefer and depend heavily on private vehicles for their transportation. This is particularly true for those living in more rural areas, where people need to travel farther distances to access services and where there is a lack of public transportation.[lxxxi] Nationally, older adults make over 90% of their trips in private vehicles and tend to travel fewer miles than the general population. A recent report by AARP notes that 74% of older adults (age 65+) are licensed drivers. [lxxxii]
- The proportion of licensed drivers and the miles traveled decreases with age. In addition, those who experience poor health and/or disability are more likely to experience difficulty in mobility.[lxxxiii] This increases the likelihood of isolation and inability to access services, visit friends and participate in community life. In our predominantly rural state with its shortage of public transportation assistance, many older Vermonters keenly feel this reality.
- In Vermont, private vehicles are the primary means of transportation, with more than 98% of all travelers riding in private vehicles on any given day. The Vermont Agency of Transportation (VTrans) estimates that the average "vehicle miles" traveled per day has increased from 32 miles in 1995 to 36 miles in 2001.[lxxxiv]
- Much concern has been raised regarding public safety and older drivers. Older drivers tend to reduce the risks they take when they drive, such as only driving during daylight hours, using seat belts and avoiding busy streets.[lxxxv] Older drivers also tend to reduce the overall miles that they drive and have a low per capita crash rate. However, because older drivers tend to be frailer than younger persons, and are more easily injured than younger drivers, the fatality rate for older drivers increases significantly when considering miles driven. According to the Insurance Information Institute, older drivers comprise 12% of all traffic fatalities, 11% of vehicle occupant fatalities and 16% of all pedestrian fatalities.[lxxxvi]
- Environmental factors such as driving conditions, road design and signage also influence the safety of older drivers. Some states have implemented policies that place limits or restrictions on driving. However, it has not been proven that such policies have any impact on safety. Instead, experts recommend improving driver assessment, treatment, and training as well as making improvements to vehicles and the driving environment in order to improve safety.[lxxxvii]
- Of the 98 persons killed in motor vehicle crashes in Vermont in 2004, 27.5% (27) of the victims were age 55 and older and 14.3% (14) were age 65 and older.[lxxxviii] Still, this represents a very small proportion of Vermont's older population.
- For those who no longer drive and who do not have ready transportation assistance from family or friends, public transportation is extremely important. In 2000, Vermont's Public Transportation system was projected to top 3 million one-way trips for the first time in the history of the program. And yet, it is difficult to provide public transportation in a rural state such as Vermont because there may not be a high enough volume of people traveling to or from the same locations to make fixed route

service efficient and affordable. Instead, Vermont's public transportation providers are challenged to design and develop creative solutions to meet the needs in rural communities, such as demand response services or route deviation services.[lxxxix]

- In many regions of the state, volunteer drivers play an essential role in helping older Vermonters to access the transportation they need to maintain their mobility and independence. According to the Vermont Public Transportation Association, in 2005, volunteer drivers provided about 30% of all Medicaid non-emergency, medical transportation trips and drove over 5.5 million miles.[xc]
- In addition to needing adequate amounts of and creatively designed public transportation, it may be necessary to offer special training to older Vermonters who have never used public transportation. Transportation providers also need training regarding the special needs of older adults as well as clear guidelines for making reasonable accommodations if older adults and people with disabilities are to be able to use their services successfully.
- Area Agencies in Aging provide much needed support to older adult transportation and invest a lot of effort into working with the transportation providers in each region of the state. For the past several years, the increasing demand for transportation, coupled with skyrocketing fuel and insurance costs, means that some AAAs have had to develop new methods to manage their transportation resources. Some AAAs have had to limit the number of trips an individual may receive or amount of money that can be spent; have prioritized the transportation based on the purpose of the trip; and have increased the coordination of trips to and from a given region. For example, instead of providing multiple individual rides, people from the same town plan trips and ride together on a specified day of the month.

Living Arrangements

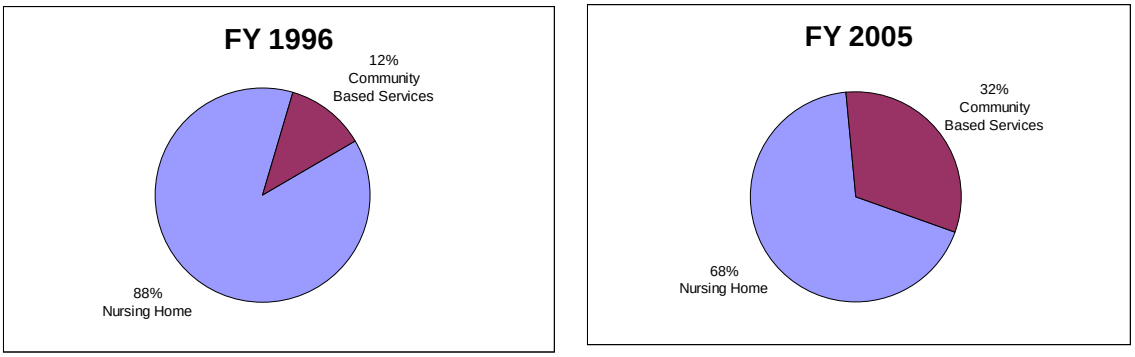
- As is the case nationally, close to 96% of Vermonters age 65 or older live in home and community-based settings, rather than in a nursing care facility.[xci]
- In Vermont, 87% of individuals age 85 or older live in home and community-based settings.[xcii]
- According to national statistics the majority of older persons live with their spouse and/or family. The latest figures show that 71 % of older men and 41 % of older women live with others.[xciii]
- Almost half of all older women are widowed (45%), compared to men who are much less likely to be widowed (14%). [xciv]
- Nationally, an estimated 416,000 grandparents age 65 and older are in households where they have primary responsibility for their grandchildren.[xcv] In addition, recent estimates indicate that in the U.S. 456,000 grandparents age 60 or older are living with and providing care to their minor grandchildren. [xcvi]

Nursing Facility Occupancy and Utilization [xcvii]

- As of December 2005, there were 43 nursing facilities with 3,465 licensed beds[xcviii].

- Ninety-two percent of Vermont nursing facility residents are 75 years of age or older and 83 percent are 65 years of age or older.[xcix]
- While 4% of Vermont residents over the age of 65 are likely to use nursing care facility, the prospect increases with age, to approximately 13% by age 85.
- While many people live in nursing facilities, there are also many who receive nursing facility services for shorter stays as nursing facilities continue to expand their ability to provide both inpatient and outpatient (for prior residents) rehabilitative services, respite and palliative care.
- In 2005, the leading reasons for admission to a Vermont nursing facility were to receive short-term rehabilitation or skilled care (64%) and/or case needs related to a significant change in functional status (27%).
- In State Fiscal Year 2005**,** 68% of public expenditures for long-term care in Vermont were spent on nursing facility care compared to 32% for home and community- based services. The impact of Act 160 is clearly evident when comparing these figures to the breakdown in 1996, before the implementation of the Act. At that time, an estimated 88% of public expenditures for long-term care were spent on nursing facility care compared to only 12% for home and community-based services.

Public Expenditures for Long Term Care



Residential Care Homes and Assisted Living Residences[c]

- Vermont's residential care homes offer a less restrictive living environment than nursing facility care, in a community-based setting. There is great diversity among Vermont's providers with a range of options in setting, size and types of services. The 100 Level III facilities offer 24-hour on-site staffing.
- As of December 2005, there were 110 Level III and IV residential care homes in the state, with 2,267 licensed beds. While the number of homes remains the same, there has been a reduction of 20 licensed beds since 2002. When put up for sale, residential care homes now appear to be sold readily when homes are in good condition to continue operation as a residential care home.[ci]
- Occupancy for residential care homes has averaged between 82 – 86%; however, there is noticeable variation in the occupancy from home to home.

- The availability of assisted living residences is a relatively new option in Vermont. Regulations for Assisted Living Residences were promulgated on March 15, 2003. Currently, there are 6 licensed assisted living residences in Vermont, with a total capacity to serve 293 people. The average occupancy for assisted living residences is 73%.
- Figures for the ERC option in the Choices for Care program show that the average age of participants in this program is 83, compared to an average age of 71 for those receiving home-based services.
- Fifty-nine licensed Level III residential care homes (59%) are ERC providers participating in Vermont's Choices for Care Program. Since ERC services were first implemented in 1996, the ERC participation has grown to serve more than 250 people per year.
- In State Fiscal Year 2000, Assistive Community Care Services (ACCS) was implemented as a Medicaid State Plan program in which Medicaid pays for certain care services provided in approved Level III residential care homes to residents who are eligible for Medicaid and need the services. The program expanded in 2003 to include assisted living residences. This program has increased the reimbursement to Level III residential care homes and assisted living residences for certain low-income residents (those at the Supplemental Security Income level) by bringing additional revenue necessary to help stabilize the residential care home and assisted living industries. This allows providers to increase the number of low-income residents served. Since the program first began in July 1999, the number of providers enrolled in the program has increased from 67 to 102 by December 2005, a 52% increase. In the first year of operation, the program provided ACCS to 544 low-income residential care home residents and grew to 713 at any point in time in 2005, a 31% increase.

Volunteer and Other Opportunities to Support Successful Aging and Independent Living[cii]

- A strong correlation exists between maintaining one's health and well-being, and remaining active and involved in one's community.
- Several thousand older Vermonters contribute to their communities each year through volunteer work with programs such as the Foster Grandparents Program, the Neighbor to Neighbor AmeriCorps Program, RSVP and the Senior Companion Program.
- According to a 2005 Foster Grandparents survey of 45 participating older Vermonters, 80% stated that volunteering for the program gave them a reason to get up in the morning; 78% said it gave them a sense of purpose to their life; 71% experienced increased self-esteem; and 78% indicated that it made them happy.
- In 2005, the Foster Grandparent Program's 134 volunteers served 2,320 children in 59 agencies and provided 101,764 hours of service throughout the state; at an estimated value of $1,628,224.
- In 2005, 2,642 RSVP volunteers served in 687 agencies, and provided 370,240 hours of service across the state; at an estimated value of $5,923,840.
- At the same time, 86 Vermont Senior Companions spent 70,051 hours providing supervision and support, assistance with a range of daily tasks and light housekeeping

to 450 older Vermonters in order to help them remain independent, at an estimated value of $1,120,816.

- The total contribution of the 3 Senior Corps Programs (Foster Grandparent, RSVP, Senior Companion) in Vermont for 2005 includes: 2,852 volunteers, services to 751 agencies and 542,055 hours of volunteer services provided at a total value of $8,672,880.
- Although you do not have to be an older adult to be a member, the Neighbor to Neighbor AmeriCorps Program provides essential support to older Vermonters and adults with disabilities to enable them to remain at home. In FY 2005 Neighbor to Neighbor members recruited 1,048 volunteers who joined them in providing assistance to 800 older Vermonters and adults with disabilities in their homes and 4,500 participants at community-based successful aging and independent living programs, providing 8,200 hours of service.[ciii]
- At least 9 of the state's 13 Vermont Public Transportation Association (VPTA) members utilize volunteer drivers to ensure that older Vermonters have access to the transportation they need to stay independent and in the community. Statewide, there are over 400 volunteer drivers who provided an estimated 34,000 volunteer hours of service in the Elders and Persons with Disabilities program component of the Section 5311 transportation service, and 56,000 hours of volunteer service for the Non-Emergency Medical Medicaid Transportation Program.[civ] Combined, the estimated value of these services equals $1,440,000.

Employment

- "Retirement" has taken on new meaning for the Baby Boom generation. Many of today's Baby Boomers intend to maintain active lifestyles after they reach the traditional age of retirement. Volunteer and work opportunities will be an area of increasing interest for Vermont.
- A December 2005 report published by AARP estimates that "by 2010, nearly twenty percent of the total U.S. work force will be age 55 or older," and that those currently working between the ages of 50 – 70 plan to be involved in some sort of work activity when they reach retirement age, or to never retire.[cv]
- Through the OAA Senior Community Service Employment Program (SCSEP), the State's Grantee, Vermont Associates for Employment and Training, placed 85 participants age 55 and older at public and private non-profit organizations and provided 42,039 hours of service at an estimated value of $672,624. Of this number, 32 participants moved into unsubsidized placement.[cvi]

NEEDS, ISSUES AND CONCERNS OF OLDER VERMONTERS

Vermont continues to find creative ways to use the limited resources it has to expand the choices and options available for older Vermonters to live as independently as possible, to respond to their preferences, to support them in making decisions and directing their lives, and to help them to remain active and contributing members of their communities. Since the 2003 State Plan on Aging was written, much progress has been made, particularly with the implementation of the Choices for Care Program, but much more remains to be accomplished. Please see the section on *Special Projects and Initiatives* for an overview of some of the projects currently underway to further our efforts at creating choices, improving access and promoting self-direction. As we begin a new State Plan on Aging, the challenge is in continuing to achieve results and in preparing to meet the needs of an aging Baby Boomer generation, in the face of a tight state economy and with level or decreased federal funding. With the aging of the Baby Boomer generation, we anticipate a corresponding increase in demands placed upon the service delivery systems and recognize that it will be more important than ever to think creatively about how to use available resources as efficiently and effectively as possible. Vermont has an advantage in that it is a small state, both geographically and population-wise. Therefore, we are able to maintain regular communication and work closely with individual consumers, advisory groups, the Community of Vermont Elders (COVE), consumer groups, state agencies, the AAAs and other community partners. These are the issues and concerns that we hear, in meetings, focus groups, at conferences and through the surveys we conduct. Regardless of which group we hear from, several consistent themes emerge.

The most frequently expressed areas of concern include:

Consumer Direction and Independent Living

- Frequently older adults and/or their families struggle to identify and find resources to meet their particular needs. Vermont's first Real Choice Systems Change grant funded by the Centers for Medicare and Medicaid Services (CMS), established a task force to study the state of Information/Referral/Assistance (I/R/A) in Vermont and make recommendations for systems improvements. In a series of focus groups held in 2001, the demand for a single, comprehensive statewide source of information and assistance (I&A) was identified as an important need. People want services to be clearly defined and to have information provided in "plain English," using non-technical language and be easy to follow. In addition, while focus group participants expressed that a toll-free number and a web site are the preferred vehicles for accessing information, they were also adamant about the importance of having access to a knowledgeable person to speak with when dealing with a crisis situation.[cvii] The October 2004 summary report of the I/R/A task force included several key recommendations, including: that agencies providing I/R/A should clearly distinguish this service from intake, eligibility determination or other service provision; that agencies providing I/R/A should be committed to helping consumers navigate the services system in order to access the services that they need; that it is critical to ensure proper staffing and training in order to provide high quality I/R/A; and that a

centralized resource file should be used and updated regularly to ensure that the most up-to-date information is provided.[cviii]

- The need to receive long-term care services in their home and the possible loss of independence is one of the most frequently cited concerns among older adults.[cix] The desire to age in place, to develop residential alternatives and to prevent nursing facility placement is of key interest to older Vermonters. We have been working hard to develop new models, identify new resources, and expand the capacity for older Vermonters to remain in their communities with a variety of residential supports. Still, need outstrips demand and more work must be done to give consumers new and expanded choices, and to have sufficient capacity to meet the need statewide. The lack of senior independent housing for some income groups, the need for improvements in design practice to ensure accessibility, and the challenges small communities face in developing and managing small scale, local projects are of particular concern.
- According to a 2002 survey, consumers of the State's community-based long-term care services were highly satisfied with the quality of services provided, especially the courtesy shown by their caregivers, the quality of communication with caregivers, with the assistance they received, and the reliability of services.
- Statewide, approximately 84.3% of respondents rated their satisfaction with the programs in which they were participating in as "excellent" or "good." Satisfaction with programs increased 4.5% from 2000, when approximately 79.8% of respondents reported the same degree of satisfaction with the programs. They were also generally satisfied with the amount of choice and control that they have, with 80.7% of respondents rating their satisfaction as "excellent" or "good." This rating increased significantly from the survey in 2000, when 71.7% of respondents reported the same degree of satisfaction with the amount of choice and control that they have.[cx] Older Vermonters clearly want to have a sense of control over their own lives and want to make their own decisions.
- The need for affordable, accessible and high quality transportation that accommodates the special needs of older Vermonters is an issue that is raised at almost every meeting, conference or focus group attended by Department staff. Access to public transportation, and for some, assisted transportation, plays a large role in whether or not one remains independent. Giving up one's license is a great concern to many older individuals. Coupled with the inability to access public transportation services, an older Vermonter's independence and self-esteem may be seriously threatened. Loss of ability to "get around" may become a determining factor in whether or not one can successfully "age in place."
- Social isolation, related to loss of mobility and contact with family, friends and the larger community/society is a key concern. Vermont's long-term care consumers are less satisfied with the amount of socialization and connections to their community, are less satisfied with the amount of contact they have with family and friends and report less mobility than the general public.[cxi]
- For many older Vermonters, having the means to maintain one's own home is key to remaining independent. High property taxes, home maintenance costs, cost of home heating fuel and related home ownership expenses impose heavy burdens on many who struggle to retain an independent life style. Advanced age and the presence of

mobility or self-care limitations are now correlated with a higher incidence of housing burden, meaning that the frailest older adults are at highest risk of being unable to age in place at home, even as care options and entitlements grow.

- There is an increasing interest in understanding better the special needs of grandparents and other older family members who are caring for children, and finding ways to support grandparents to maintain their connection with children.

Role of Senior Centers and Community Nutrition Programs

- For many, Vermont's senior centers and community nutrition programs can play an important role in helping to maintain connections with the community and contribute to general well-being, but many centers are struggling to stay open in the face of mounting financial pressures and changing demographics. While the state has not yet adopted a formal definition distinguishing senior centers and multi-purpose senior centers. Multi-purpose senior centers are generally defined to be those that provide social contacts, nourishing meals, health promotion, disease prevention services, community-based activities and other support. Multi-purpose senior centers in rural states are faced with the challenge of providing access to these services that will promote successful aging and independent living for older adults. Furthermore, the needs and preferences of older adults are evolving over time, particularly as Baby Boomers begin to enter the service eligibility network, requiring senior centers to develop new ways to deliver effective, targeted services that appeal to the next generation. Service delivery approaches that worked in the 1990's may no longer be the most effective method for providing services to older adults now and in the decades to come. Moreover, public perception by non-users of senior centers tends to be negative, often equating these centers as "being for old people"[cxii] and "comparable to a nursing facility." With that in mind, Vermont requested and received federal funding to implement local projects designed to test and evaluate methods that will meet the emerging needs of their rural senior center customers. Please see the section on *Special Projects and Initiatives* for more information about the senior center federal funding. In addition to the federal funding, in State Fiscal Year 2005, the legislature appropriated one-time funding to assist Vermont's senior centers to maintain operations or enhance services. Finally, while AAAs provide financial support to many of Vermont's senior centers and community nutrition programs on an on-going basis, it is important to note that the federal and state funding awarded were one-time funds and are not expected to be available in future years.

Health Care

- Vermonters continue to wait and work for substantive improvements in affordable, accessible coverage for health care, including adequate coverage for long-term care services and prescription drugs. During the 2006 legislative session much attention was focused on efforts to improve access to affordable health care for all Vermonters.

Democrats, Republicans and Progressives all agreed that reform was needed, and as a result, enacted health care reform legislation (H.861) which calls for many health care system improvements, including the creation of a new health insurance plan, Catamount Health, aimed at providing coverage to thousands of currently uninsured Vermonters.

- For many years, concerns about rising prescription drug costs and lack of insurance coverage for these costs topped the list of concerns for many older Vermonters. COVE and the AAAs have been leaders in providing information and developing resources to improve access and address these concerns. Older Vermonters have been vocal about the need for real reform of the pharmaceutical industry coupled with affordable and accessible prescription drug coverage.
- When Congress passed the Medicare Modernization Act in 2003, some of the most sweeping changes to this program were enacted since the program began in 1965, with the goals that Medicare beneficiaries would save money on prescription drugs, receive better preventive health care and have improved access to doctors and medical services, particularly for those in rural areas.[cxiii] However, because Vermont's pharmaceutical coverage for low-income individuals was better than some of the changes to be enacted with the new Medicare Part D, many advocacy groups and agencies, including the AAAs, the Department, the Office of Vermont Health Access (the Medicaid Division), COVE and numerous other groups, worked very hard to ensure that Vermont beneficiaries would not lose coverage with the implementation of Medicare Part D. In addition, much effort was placed on planning for implementation; and on outreach and education for Medicare beneficiaries as well as various health care providers, pharmacies and other providers who needed information to understand the changes. Please see the *Special Projects and Initiatives* section for Vermont's efforts and activities related to the MMA.
- The need for coverage for eyeglasses and hearing aids, and the insufficient funding available to purchase dentures and dental care create significant problems for many older adults. These health aids can serve as essential tools for the prevention of problems such as malnutrition, communication difficulties, loss of independence and life-threatening falls. Although Vermont Medicaid provides no coverage for eyeglasses or dentures, it does provide up to a $475 annual cap on other dental expenditures and does provide coverage for analog and digital hearing aids.[cxiv] Still, there are many older Vermonters who do not qualify for Medicaid assistance and experience gaps in other health insurance coverage. The new Flexible Choices option in the Choices for Care Program will help to alleviate some of this by allowing individuals to purchase items not usually allowed under Medicaid.

Workforce Issues

- Personal care attendants and licensed nurse's aides are in short supply. The problem is exacerbated by increasing demand for the services, low wages and poor or non-existent benefits. Staff shortages and the frustration felt especially by nursing facility caregivers who had insufficient time to provide quality care create additional barriers to recruiting and retaining people to provide these important services.[cxv]

- Shortage of available and well-trained caregivers is an ongoing problem, and is critical to supporting long-term care in home-based settings. There is an increasing need for home care providers who can offer nighttime and/or weekend respite care, and an apparent shortage of caregivers to provide this type of assistance. Nursing facilities and residential care homes also report significant staffing shortages. The need to increase pay and create better equity of pay for caregivers has also been raised as an issue by caregivers, social service providers and advocates.
- The importance of supporting and encouraging family caregivers, including the need to provide them with information they need to hire and manage paid caregivers, is noted by advocates and family caregivers themselves. In addition, paying spouses for caregiving is an option that Choices for Care will address over the coming year in response to advocates who have highlighted the economic hardship that family caregivers face in providing care.

Economic Security

- Impoverishment associated with long-term care and institutionalization is of great concern. While Medicare provides coverage for many medical needs, it is not designed to cover the costs of long-term care. Private insurance for long-term care remains unaffordable for most elders. Elders and family caregivers want factual information and help accessing the full range of long-term care options and how to pay for them.
- Especially in these uncertain financial times, older Vermonters living on fixed incomes continue to worry about the affordability of health care costs. Like much of the country, Vermont's economy has been unstable with certain state expenditures such as the growing population in the correctional system and an expanding Medicaid budget acting as specific pressure points to keeping the state budget on target. To date, we have been able to avoid potentially negative cuts in services due to savings in the nursing facility Medicaid budget, and the hope is that the Choices for Care Program will generate more such savings as increasing numbers of people choose to remain in the community.
- In October, 2005, Vermont implemented an 1115 federal Medicaid demonstration waiver, the Global Commitment to Health. The goals of the Global Commitment to Health waiver are to: 1) provide the State with the financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) explore new ways to reduce the number of uninsured Vermonters; and 3) foster innovation in health care by focusing on health care outcomes. OVHA will manage all enrollees under the Global Commitment to Health waiver; however, Medicaid beneficiaries enrolled in Choices for Care are not enrolled in the Global Commitment to Health waiver.
- Uncertainties about the future of Social Security, the real impact of the Medicare Modernization Act over time, health insurance, and private pensions are of great concern to most older adults. This will be an area of interest and concern in the months and years ahead.

- The ability to afford rising property taxes, in comparison to incomes, and to cover other costs associated with home ownership is a concern to many older adults. Many older Vermonters live in older homes that are more difficult to modify for accessibility and are more expensive to heat and maintain. The problem is compounded for older Vermonters with no or decreased investment incomes.
- Rising fuel costs impact many parts of the economy, from individual home heating costs, to transportation, costs for building and other materials, and many other services.
- Even slight shifts in the cost of prescription drugs, health care, transportation and housing have a dramatic impact on those living on fixed incomes. A significant percentage of our older population struggle continually to make ends meet. As discussed earlier in this plan, spending by older adults for health insurance and drugs has increased steadily over time.

GOALS, OBJECTIVES AND PROGRAM RESOURCES FOR FEDERAL FISCAL YEAR 2007 –TO 2010

Planning for the Future

In the State Plan for Federal Fiscal Year 2003 – 2006 the Department identified six broad goals on which we would focus our efforts. Many of them remain viable and will continue to be an important focus of our work. Generally, we have reformulated some of the goals, consolidating and adding emphasis when necessary. To these we add a goal related to ensuring that Vermont elders have access to improved information and access to services through the development of Aging and Disability Resource Centers (ADRC).

One of the particular challenges facing the Department and its grantees in planning for the future, is that aside from the implementation of the National Family Caregiver Support Program (NFCSP), funding for the Older Americans Act has remained stagnant for the past several years, with some programs experiencing decreased funding. Nor does the OAA funding adequately provide the resources needed by the AAAs to keep pace with the information system technology changes necessary to do their work. AAAs were fortunate in 2006 to receive significant additional funding from the State Legislature to help cover the additional costs associated with assisting Medicare beneficiaries during the implementation of the Medicare Modernization Act (MMA), fuel, and for future years to help with AAAs meet the increased demand for services in the face of rising expenses.

While the majority of benefit programs and services available to older Vermonters are funded by federal and state government, there are many additional sources of support, ideas and inspiration which come from individuals and communities. In fact, some of the best ideas for promoting healthy aging and supporting family caregivers have come from our communities. We look forward to working with Vermont's AAAs, senior centers, community meal sites, adult day programs, home health agencies (HHAs) and other community partners to identify innovative programs and approaches as we work to meet the needs of a growing elder population.

Goals and Outcomes

The following broad goal statements and outcome measures are linked to the specific programs and strategies within the Resources section of this plan. Each Goal Statement is applicable to one or more of the defined Resources, which incorporate the Department's current approaches and strategies. Within this section each identified Resource includes one or more identified Objective(s) for the 4 -Year Plan. Vermont's Goals and Resources align clearly with the four program goals included in the federal AoA Strategic Action Plan, including: 1) increase the number of older adults who have access to an integrated array of health and social supports; 2) increase the number of older adults who stay active and healthy; 3) increase the number of families who are supported in their efforts to care for their loved ones at home and in the community; and 4) increase the number of older adults who

benefit from programs that protect their rights and prevent elder abuse, neglect and exploitation. Vermont's broad goals are to:

1. **Develop Aging and Disability Resource Centers (ADRC) as highly visible and trusted places in the community where older Vermonters and family caregivers can go to receive comprehensive Information, Referral and Assistance, streamlined access to services and help in planning to meet their future long-term care needs.**

   Outcome Measures:

   - Development and designation of Aging and Disability Resource Centers, starting in two pilot areas of the State, with the goal of statewide expansion in future years.
   - Increased number of I/R/A calls, and number of hits on the ADRC website, anticipating an increase in both over time.
   - Increased number of referrals to ADRCs.
   - Increase in the number of and sources making referrals to ADRCs.
   - Positive results from consumer satisfaction surveys regarding the degree of satisfaction with the overall quality of ADRC services.
   - Positive results from consumer satisfaction surveys regarding the knowledge of and level of support provided by ADRC staff.
   - Positive results of consumer satisfaction surveys regarding their ability and the time needed to access services.
   - Decreased processing time for applications for key services and programs.

2. **Enhance the ability of older Vermonters to live as independently as possible, actively participating in and contributing to their communities, by expanding the options available, increasing consumer choice and control, and maximizing the value of public resources.**

   Outcome Measures:

   - Increased number of individuals served and volume of services provided in the Choices for Care Program, adult day services, nutrition services, information and assistance services, and case management.
   - Improved access to and flexibility of services through the development and implementation of ADRCs, integrated care organizations, and Flexible Choices as a service delivery option in the Choices for Care Program.
   - Improved consumer satisfaction with the quality of services.
   - Increased satisfaction with the amount of choice and control when planning services.

3. **Enhance the ability of Vermonters of all ages to make healthy lifestyle choices by developing a Healthy Aging Plan for Vermont. The Plan will address specific chronic conditions and supportive services that promote healthy aging and increase the awareness of the benefits of engaging in programs and activities that will lead to improved physical and emotional well-being. As part of this effort, Vermont will continue to shift the balance of long-term care funding toward services that expand our capacity to promote and provide prevention-based systems of service. Vermont will also support efforts to increase the number of health care and human service professionals with training in geriatrics and gerontology; specifically as they related to health, well-being and chronic disease management.**

   Outcome Measures:

   - Improved health, well-being and independence of older Vermonters as measured by self-reporting related to: (1) low risk of disease and disease-related disability, (2) maintenance of high physical and mental function, (3) engagement with life; and (4) living with dignity and independence.
   - Increased access to evidence-based practice and promising practice programs that promote healthy aging and independent living.
   - Increased enrollment in gerontology and geriatric specialty programs.

4. **Continue to support family caregivers by developing and strengthening of multifaceted systems of services that provide needed support and resources to maintain their caregiving role.**

   Outcome Measures:

   - Positive results from caregiver surveys regarding the degree to which services help them to maintain their caregiving role.
   - Positive results from caregiver surveys regarding the degree of satisfaction with caregiver services provided.
   - Expand availability of all five categories of National Family Caregiver Support Program services in each AAA planning and service area throughout the state. (Please see additional details about Vermont's plans to support family caregivers in the description of *NFCSP and Related Programs in the Title III* section of this State Plan on Aging.)

5. **Develop a system of continuous quality improvement that includes effective evaluations of those services and organizations funded under the Older Americans Act, as well as those linked to these services and organizations through the community network of providers.**

   Outcome Measures:

   - Tracking of outcome-based performance indicators of services administered by the Department, provided through the network of community providers (AAAs, HHAs, adult day programs as well as consumer-directed and surrogate-directed services).
   - Positive results from consumer surveys regarding the degree of consumer satisfaction with the quality of services.
   - Positive results from consumer surveys regarding the degree of consumer satisfaction with the amount of choice and control when planning services.

Resources

Human Resources

Vermont is proud of the many dedicated people working at all levels of the aging network. We are fortunate to have a large corps of highly qualified and committed individuals, many of whom have dedicated much of their adult life to ensuring that older Vermonters are able to live as independently as possible and to actively participate in their communities. Thousands of paid and volunteer staff are at work every day, providing personal care, delivering nutritious meals, driving older Vermonters to adult day programs and medical appointments, and working with older Vermonters and family caregivers to develop plans to stay at home.

As discussed earlier in this plan, Vermont continues to struggle with a shortage of caregivers; and there is growing concern about this issue with the aging of the Baby Boomer generation and the likelihood that there will be an even greater need for professional caregivers.

Workforce

As both the populations of older Vermonters and younger adults with physical disabilities grow, the need for direct care workers is becoming more and more apparent. Vermonters who need long-term care rely on these individuals whether they reside at home, in nursing facilities, in assisted living residences or in residential care homes. Their role in the long-term care system must be recognized.

Developing and maintaining a stable workforce that is valued, trained and adequately reimbursed is a goal of the State Unit on Aging. The first workforce study, published in

2001[cxvi], delivered 34 recommendations to the Commissioner. The original task force continued to work on those recommendations until the Real Choice System Change grant that supported their work came to an end. The Workforce Council found organizations willing to continue their efforts: the statewide Healthcare Workforce Partnership and COVE under their Better Jobs/Better Care (BJBC) grant. Department staff participate in both initiatives. Significant efforts have gone into raising awareness about the importance of direct care workers and as a result, they are now a focus of the Healthcare Workforce Partnership.

The Real Choices grant provided start-up funds for the Vermont Association of Professional Care Providers (VAPCP). That fledging organization, supported by COVE, is gradually growing its membership and will be key to continuing efforts to draw public attention to the value of direct care workers. Members of VAPCP star in a new video called "Stand Up and Tell Them" that showcases direct care workers and the role they play in the long-term care system.

The BJBC three-year grant is focused on instituting culture changes in various organizations that provide long-term care. The project is working on culture change initiatives with nursing facilities, adult day programs, residential care homes and home health agencies. Better Jobs/Better Care:

- "recognizes the essential relationship between the quality of care for people with long-term healthcare needs and a stable, well-trained, adequately compensated direct care workforce; and,
- recognizes the emerging care gap between the projected increase in need for long-term care services and the high turn-over rates, low retention rates, and shrinking size of the traditional labor pool for service providers."

Through the BJBC grant resources, COVE can now list the following project activities that move us a few steps closer to our goal:

- development of "Care Well", a core curriculum for personal care attendants;
- development of "Beyond the Basics", two continuing education series for direct care workers in dementia care and palliative care;
- Support, technical assistance and training to BJBC participating organizations in meeting their goals to improve recruitment and retention of direct care workers;
- Centralized training opportunities to all twelve participating agencies; and,
- Development, in collaboration with the Vermont Assembly of Home Health Agencies, Residential Care Homes of the Vermont Health Care Association and the Vermont Association of Adult Day Services, of employer "best practices" initiatives that meet the individual needs of these diverse groups.

In addition, work is being done to determine the need for, feasibility of, and best mechanism for bringing a direct care worker registry to Vermont. COVE is working with all the BJBC partners to determine how the work started under BJBC can be sustained after the grant ends on December 31, 2006.

The Vermont Legislature recently appropriated funding for the Department to conduct a study and report the results of the needs assessment and recommendation to the Legislature. The study is described as follows: *The commissioner of disabilities, aging, and independent living shall perform a needs assessment regarding present and future workforce issues of direct care workers in Vermont. The assessment shall focus on potential problems regarding quantity, quality, stability, and availability of workers, specifically as they apply to long-term care services and supports provided to Vermont's elderly and disabled populations. At a minimum, the assessment shall identify the potential problems and opportunities projected through 2030 and shall include recommendations for addressing these problems in the near and long term.* This study will lay the groundwork for future efforts.

Funding

Older Americans Act funds make up only a portion of the financial resources available to meet the needs of the older population in Vermont. As discussed earlier, funding has not kept pace with inflation, or the demands of an increasing aging population. The Department is intrigued by some of the ideas contained in the administration's OAA reauthorization proposal and the opportunities they might present to use OAA funds more flexibly and creatively to promote consumer choice and control, as well as the possibility for allowing cost-sharing in some OAA services.

Area Agencies on Aging also devote extraordinary amounts of time to seeking local and/or private support for the programs and services they offer. Over the years, it has become increasingly difficult for AAAs to secure these resources as town budgets are strained and private sources must balance and prioritize funding requests from multiple organizations. Still, local fundraising efforts are important to maintain, not only for the potential to maintain or increase funding, but also related to the opportunity it provides to educate the local community about the role that AAAs play in helping older adults to remain independent and in supporting family caregivers.

Throughout this State Plan on Aging, there has been discussion about the growth Medicaid as a funding resource for older adults. While there will always be challenges in finding the resources to meet both short and long term goals, the Department is encouraged by the success of the past several years in implementing Act 160 and more recently with the implementation of the Choices for Care Program. We will continue to explore new ways to collaborate with our federal, state and community providers to develop and expand home and community-based services, and to maximize consumer choice and control in services.

Data

Collecting and analyzing data about the programs we administer and the people we serve is important to evaluating our success in meeting older Vermonters' needs and achieving our stated goals. It allows us to identify unmet needs and gaps in services, and to plan for

improvements to the available services and resources. Presently, the Department utilizes the Social Assistance and Management Systems (SAMS) database to manage the information related to the OAA and other funding sources. Data management is a rapidly developing field, with new software and resources being produced every year. In fact, the Department recently upgraded the SAMS database to SAMS 2000 and implemented a central server with AAAs to make the storage and management of information as efficient and affordable as possible. The Department is now exploring the possibility of sharing Choices for Care eligibility and service authorization data with local partners, including AAAs and HHAs, so that they can access this information only for the consumers to whom each agency provides services. This would improve the speed and accuracy of shared information.

In 2001, the Department initiated a project to measure Vermonters' future needs for long term care and the system's capacity to meet those needs. With the assistance of a consultant, the Department has developed a model to project needs and capacity up to the year 2015. *Shaping the Future of Long Term Care and Independent Living* is a yearly report that is intended to be living document, adjusted annually to reflect the changing demographics and trends. By using a rolling 10-year forecast for long term care needs and use, the Department can continually plan for the future. The report also features a "County Profile" for each of Vermont's 14 counties highlighting major long-term care indicators.

Special Projects and Initiatives

The Department is fortunate to have many effective collaborative relationships with the federal government, other state agencies, and our community partners. Through our efforts, a number of special needs have been identified; and we have implemented special initiatives to address them.

Aging and Disability Resource Center Grant

In October 2005, the Department was awarded a three-year $800,000 grant from the AoA and CMS to develop Aging and Disability Resource Centers (ADRC) that will serve as highly visible and trusted places where people can turn for information on the full range of long-term support options and a single point of entry for access to public long-term support programs and benefits[cxvii] for older Vermonters and younger adults with physical and/or developmental disabilities or traumatic brain injury (TBI). The key functions of ADRCs are to provide comprehensive information, referral and assistance (I/R/A); comprehensive assessment; eligibility screening; eligibility determination; and help planning to meet one's needs into the future. ADRCs will not only provide information and access to publicly funded programs and benefits, but will also provide information and help consumers to access private pay services. In other words, the ADRCs will provide one-stop access to long-term support information and services. Consumer and key stakeholder input will inform every part of the project. Key partners include AAAs, the Vermont Center for Independent Living (VCIL), developmental services providers,

the Traumatic Brain Injury Association of Vermont, the Office of Vermont Health Access, the Department for Children and Families, and Vermont 2-1-1.

In our first year of the grant, Vermont's efforts have focused on beginning the work to improve and expand the I/R/A functions performed by the AAAs, plan for the development of two pilot ADRCs serving additional populations, streamline the eligibility process for Medicaid and Medicaid Long-Term Care and creating a seamless link between the ADRCs and the Medicaid eligibility determinations. In the second year of the grant, we will begin providing ADRC services to younger adults with physical disabilities and the TBI population. Finally, in the third year of the grant, we will provide ADRC services to individuals with developmental disabilities.

Project outcomes will include: (1) informed choice of LTC options for older Vermonters and younger adults with disabilities; (2) streamlined access to LTC eligibility for older Vermonters and younger adults with disabilities; (3) easier access to home- and community-based services; and (4) a sustainable ADRC model that can be expanded statewide.

Vermont Real Choice Systems Change Comprehensive Systems Reform

Under the umbrella of Vermont's Agency of Human Services (AHS), the Department is collaborating with OVHA to redesign a system to integrate primary, acute, and long-term care services for older adults and adults with physical disabilities. The primary goals of this project are to:

- Improve access to services through integrated care organizations by using an interdisciplinary team and a single care plan.
- Permit more consumer-focused flexibility in what services are provided and how they are provided.
- Develop a core reimbursement system for integrated care organizations.
- Improve services and supports provided by integrated care organizations.
- Ensure that services are available that match consumers' needs and preferences.
- Build quality management systems.

A commitment to integrated care is the starting place for the reform. The Department is building upon the lessons learned from the Vermont Independence Project's Care Partners program (e.g., physical co-location of case management in a primary care setting) and the planning for the Program for All-Inclusive Care for the Elderly (see below). To address the identified problems, the project will undertake strategies to integrate funding streams for Medicaid and Medicare, and commercial insurance, if possible. To accomplish the project goals, the Department has convened a core planning team to develop the model for an integrated care organization to serve frail, vulnerable and chronically ill older adults and adults with disabilities, and to develop the policies and procedures that need to be in place for this model to work. In addition, a very active

community advisory committee, including consumers and other stakeholders, meets regularly to provide input to the Department as we develop the integrated care model.

Program for All-Inclusive Care for the Elderly

Programs for All-Inclusive Care for the Elderly (PACE) offer an innovative approach to coordinating and providing all of the preventive, primary, acute and long-term care services that older adults need in order to remain in the community. Through this integrated model of services, Medicare and Medicaid financing is combined and allows consumers and the providers working with them flexibility in managing their health and social needs.[cxviii] In Vermont, the Champlain Long-Term Care Coalition (CLTCC), serving Chittenden and southern Grand Isle Counties, and the Rutland Long-Term Care Coalition (RLTCC) serving all of Rutland County, are collaborating to develop and implement a Program of All-inclusive Care for the Elderly (PACE). Once established for eligible residents of these three counties, PACE Vermont will provide a community-based, comprehensive health care delivery system which will enable the enrolled population of elders to remain independent within the community, thus avoiding placement in a nursing facility. In January 2006, the Vermont Agency of Human Services as the State Administering Agency for Vermont's PACE submitted the provider application to CMS for PACE Vermont, Inc. for their approval. Plans are underway to establish the first PACE Site in Chittenden County. PACE Vermont has received approval from the State of Vermont Department of Banking, Insurance, Securities and Health Care Administration and has obtained the necessary local permits to begin construction. Prior to opening, PACE must undergo a readiness review to verify that it meets all of the required provisions for a PACE site and the application to CMS must be approved. Once approved, PACE will become a service option within the Choices for Care Program. The projected opening date is in the Fall of 2006. A second PACE Site is planned for Rutland County as part of a senior housing development. An interim site might be co-located with the Interage Adult Day Program in the center of Rutland City. PACE Vermont is projecting that the provider application for the Rutland PACE to the State in Fiscal Year 2007.

Real Choice Systems Change Grant: Integrating Long-Term Supports with Supportive Housing

A current component of the Department's commitment to developing residential alternatives is the Supportive Housing Project. In October 2004, the Department was awarded a 3-year federal grant from CMS to remove barriers that prevent Medicaid-eligible individuals with disabilities of all ages from residing in the community or in the housing arrangement of their choice. In order to ensure that consumers have a voice to remain in the housing settings of their choice, Vermont needs to build the housing and supportive services capacity in the community.

The primary target populations for this grant are older adults who need long-term supports coordinated with affordable and accessible housing, older adults living in nursing homes who could live in supportive housing if it were available and those dually eligible for Medicare and Medicaid. Most grant activities will also benefit other adults with disabilities. Grant objectives focus on the following areas:

Access: Build consumer access to supportive housing that consumers prefer by making strategic investments in critical resources that spur development, preservation and enhancement of supportive services. Work in this area is concentrated in three main activities: 1) provide consulting services and technical assistances through Cathedral Square Corporation for at least 10 projects that need help preserving existing housing and supportive services, guidance in the initiating the development of housing and supportive services, or assistance to enhance the availability of housing and supportive services in the community. Additionally, to build capacity to respond to projects in the community that need assistance, Cathedral Square Corporation will invest resources in critical learning and knowledge-building; 2) provide funding to build early momentum for the development of housing and supportive services. Funding will be targeted to three priority needs areas where projects have been difficult to develop or where housing and supportive service projects are needed; and 3) provide funds to support the development of an affordable assisted living project sponsored by a public housing agency.

Medication Assistance: Study, analyze and establish medication assistance best practices within legal, unlicensed supportive housing and ensure consumer satisfaction with suggested practices.

PACE: Prepare to increase the aging in place capacity of affordable and accessible supportive housing by exploring the viability and feasibility of co-locating two PACE sites within affordable and accessible housing. Work under this objective is targeted within Chittenden and Rutland counties.

Senior Center Federal Funding

In Federal Fiscal Year 2006, through the efforts of Congressman Bernard Sanders, the Department was fortunate to receive federal funding from the AoA to increase access to and participation in Vermont's rural multi-purpose senior centers. A comprehensive system of community-based health and social services for older adults is necessary to support independent living, thereby preventing institutionalization. Since multi-purpose senior centers are often the first source of support for social contacts, nourishing meals, and health promotion and disease prevention services, these centers are ideally situated to offer community-based activities that support the intellectual, emotional, physical, vocational and spiritual health of older adults. A multi-purpose senior center may be defined as an entity that is accessible (physically and financially), and provides a variety of services for older adults, intended to promote successful aging and independent living, including but not limited to: nutrition; health promotion and disease prevention; socialization; and information and referral.

On a statewide level, Vermont intends to increase awareness of and participation in senior center programs that promote health, socialization and independence for older adults. The significance of this Senior Center project from a national standpoint is to demonstrate that multi-purpose senior centers in rural areas can be operational and meet the emerging needs of the rural senior center customer. Although we expect that activities under this project will be wrapping up early in Federal Fiscal Year 2007, the benefits and lessons learned will last into the future.

Real Choice Systems Change Quality Assurance and Quality Improvement for Home and Community-Based Waiver Services

The Department is one of nine 2004 CMS Real Choice Systems Change Quality Assurance/Quality Improvement grantees. This funding from CMS is being used to develop a comprehensive quality management system across the Department's Division of Disability and Aging Services (DDAS) waivers over a 3-year period that began in September, 2004. The quality management system will be based on the expectations contained within the CMS Quality Framework. The home- and community-based services available under these waivers are provided to individuals with developmental disabilities, older adults, individuals with physical disabilities, and individuals with traumatic brain injuries.

The goals of the grant are to effect enduring systems change that fulfills Vermont's commitment to ensure the health and well-being of individuals receiving waiver services within Vermont's home-and community-based, long-term care system; and to provide a comprehensive quality assurance and quality improvement management system in the HCB waivers utilizing the CMS Quality Framework.

Grant funds will be used to: 1) develop a Quality Management Plan addressing the home- and community-based waiver services; 2) include consumers, their families and community members as active participants in Vermont's quality management activities; 3) develop and implement quality management activities to improve supports and services to older Vermonters and those with disabilities; 4) develop a technology-based system to manage and analyze critical incidents; and, 5) develop an ongoing system of technical assistance to all providers of services across age and disability, and provide training to service recipients and relevant staff.

The outcomes of this grant include: 1) development of a comprehensive, Quality Management Strategy Document that incorporates the CMS Quality Framework for use in the HCB waiver services; 2) use of a set of quality indicators that incorporates the CMS Quality Framework to guide the delivery of services; 3) implementation of comprehensive quality management activities that will guide on-going quality improvement activities within each waiver; 4) implementation of multiple discovery activities and data collection that include direct participant experience within each HCB waiver; 5) development of a technical assistance manual to instruct staff, volunteers, or

participants in the implementation of creative methods of information gathering activities; 6) implementation of a system of technical assistance that includes problem solving, training and consultation in the delivery of quality services to service providers within each HCB waiver services; 7) implementation of a technology-based critical incident management system to assist quality assurance staff in assessing the quality of services in HCBS waivers; 8) the inclusion of consumers and family members in the design, development and implementation of multiple quality management activities within each HCBS waiver; and 9) implementation of a pilot project to hire consumers to participate in the evaluation of services.

Dementia Care Grant: Staying the Course in Alzheimer's Care: Caregiver Friendly Services and Supports

The Department was awarded its second three-year AoA Alzheimer's Disease Demonstration Grant to States in July, 2004. Annual grant funding of $311,150 will assist the Department in its goal to expand existing services; and provide enhanced continuity of care to individuals with Alzheimer's Disease and Related Disorders (ADRD) and their family caregivers. Improving the system of care delivery will increase the capacity for family caregivers and other support persons to provide care to individuals with ADRD and may delay or prevent nursing facility admission. In implementing this grant, the Department will coordinate its efforts with other State programs such as Choices for Care and the NFCSP and with Vermont's AAAs, HHAs, Community Mental Health Centers, Primary Care Physicians, and other professional caregivers. The grant includes three main objectives:

- Develop, enhance and coordinate effective interventions and supportive services for individuals with ADRD and their family caregivers on-site at Primary Care Physicians' practices.
- Expand the Dementia Respite Program to provide support and respite to an increasing number of individuals with ADRD and their family caregivers.
- Provide education and disseminate information about ADRD and dementia caregiving to professional and family caregivers.

These objectives will be met through the following activities:

- Establish partnerships between Primary Care Physicians, Community Mental Health Centers, AAAs, HHAs, adult day programs and other community providers.
- Coordinate activities and expand the Dementia Respite Care Program that will provide support and respite for family caregivers of individuals with ADRD.
- Develop and implement regional caregiver wellness programs in communities where gaps in services have been identified.
- Provide on-site dementia care training and mentoring to primary care physicians and their nursing staff.
- Provide training on dementia care and family caregiving issues to Elder Care Clinicians and Case Managers.

- Provide training on dementia care to support persons of individuals with a dual diagnosis of a Developmental Disability and Dementia.
- Develop and distribute resource information on ADRD to professional and family caregivers.

Flexible Choices

Vermont is one of 11 states funded by the Robert Wood Johnson Foundation to expand the Cash and Counseling model. Flexible Choices is Vermont's Cash and Counseling program and it seeks to give consumers maximum flexibility as they manage their long-term care. As an option within Choices for Care, Flexible Choices offers yet another way that consumers can self-direct their care to create fulfilling lives for themselves in their own communities. The goals of the Flexible Choices option are:

- To give consumers maximum control over their long-term care resources.
- To support consumers in articulating their personal goals and developing plans to meet those goals.
- To increase the efficient use of resources by supporting consumer choice.

The unique features of Flexible Choices are:

- It "cashes out" a consumer's care plan so he/she can plan their care with a dollar allowance rather than a set of pre-defined services.
- It allows consumers to apply that allowance to their specific needs rather than working to match allowed services to those needs.
- It allows consumers to "save" a portion of their allowance from month to month to make major purchases of goods they might need (home modifications, for example) and to prepare for unexpected expenses.
- It allows a portion of the allowance to be given to the consumer in cash, letting them purchase needed services, such as minor home repairs, on-the-spot.

Current consumer- or surrogate-directed participants of the Choices for Care program have received notice of the imminent start of the Flexible Choices service delivery option. The Project Director has presented the model to all Choices for Care Regional Waiver Teams as well as other interested groups. The Department expects to start enrolling a pilot group of 50 participants during the summer of 2006.

Governor's Commission on Healthy Aging

Vermont is an aging state, with a growing older population that is projected to more than double from 1990 to 2020. [cxix] For many reasons, including quality of life and burgeoning health care costs, it makes sense to find ways to encourage people to stay as healthy as possible. As part of that effort, the Governor's Commission on Healthy Aging was created and has met several times since September 2005. Lt. Governor Brian Dubie

is the chair and works with 15 members representing a variety of stakeholders, including the Department. The Commission is carrying on the efforts started by the Successful Aging and Independent Living Task Force.

The role of the Commission is to:

- Help prepare our state for the changing demographics and increase in percentage of people over the age of 65.
- Build a community of individuals and groups with an awareness of how our state will be impacted by this shift in demographics.
- Build upon best ideas and best practices.
- Guide legislation.
- Impact the landscape by influencing budgets that are responsive to aging issues.

The Commission is focusing on 4 efforts this year:

- Developing a Healthy Aging Plan, which builds on goals and objectives found in other State plans: dementia and Alzheimer's Disease risk reduction and early interventions; osteoporosis; oral health; diabetes; social and recreational opportunities; smoking cessation; transportation; housing; and community-based assistive and supportive services.
- Support efforts to develop a Center on Aging at the University of Vermont and Fletcher Allen Health Care.
- Support efforts to increase the number of health care and human service professionals with training in geriatrics and gerontology, with an emphasis on health, well-being or chronic disease risk reduction and management.
- Develop "toolkits" on healthy aging that Commission members can use in their role of community ambassador.
- Develop awards for those individuals who have excelled in the field of healthy aging.

The Commission will continue to educate itself about evidence-based and promising practices in Healthy Aging and coordinate its efforts with the Blueprint for Health.

Medicare Modernization Act Activities

The Department, AAAs, advocates and providers in the aging network have been immersed in Medicare Modernization Act activities, particularly the planning and implementation of Part D, for the last 18 months. The Vermont Legislature charged the Department with the development of an outreach and education plan for Medicare Part D. The plan had to address outreach and education for all Medicare beneficiaries in the State, with a specific focus on people who were dually eligible or eligible for the State Pharmacy Assistance Program. The following organizations are just a few of the partners assisting with the work: the Department, AAAs, the State Health Insurance Assistance Program (SHIP), Long Term Care Ombudsman, Health Care Ombudsman, Vermont

Assembly of Home Health Agencies, Vermont Medical Society, Community of Vermont Elders, the Social Security Administration, Vermont Department of Health, Vermont Center for Independent Living, the Office of Vermont Health Access and the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

Prior to the November 15th enrollment start date, the SHIP organized educational events that were sponsored by all 14 hospitals in the state. Vermont's Lieutenant Governor decided that outreach about Medicare Part D was vitally important to seniors and persons with disabilities in this state, and agreed to attend all the hospital-sponsored events. The turnout was excellent and along with Part D material, people were given a folder with information about steps to healthy aging.

Between the SHIP and the Department's efforts, over 100 educational events were held at senior centers, meal sites, congregate housing sites, residential care homes, nursing facilities, town halls and libraries around the state. Legislators also requested educational events for their constituents and all their requests were honored; and many other providers received in-service training for their staff. The SHIP provided several in-depth trainings for all partners in the aging network.

Last fall, thousands of Medicare Part D flyers were mailed to town clerks' offices, physicians' offices, dentists, libraries, hospital social workers, nursing facility social workers, residential care homes, AAA offices, adult day centers, home health agencies and legislators.

The Department has been responsible for convening two large planning groups (one focused on legislation necessary to convert our State Pharmacy programs to a wrap-around program for Part D; and the other focused on outreach and education for beneficiaries, advocates and providers). The Department is responsible for ensuring that communications from the CMS are sent out to the groups, developing and distributing public service announcements, communicating Part D problems to CMS, and disseminating solutions to the group.

The SHIP has played a major role in assisting beneficiaries and their families with the new Medicare benefit. They also assisted with the low-income subsidy applications and will continue to handle that task. They have also fielded countless phone calls; spent time in the homes of beneficiaries, helping them figure out which plan best suits their needs; and advocated with CMS and the State legislature when problems occurred at the start of the program. Vermont chose to auto-enroll its State Pharmacy members and the SHIP helped educate consumers about this process and assisted them if they were interested in knowing whether their auto-assigned plan was a good fit for them. If the beneficiary decided to switch to another plan, the SHIP Counselor assisted with that change. They provided a similar service to people who were dually eligible and auto-assigned to a plan by CMS.

The Information and Assistance Specialists (I&A) at the Senior HelpLine saw the number of calls increase significantly as people began calling with questions about Part D. The

SHIP Counselors made sure that I&A staff had the knowledge to answer the initial questions, and each agency developed a protocol for transitioning callers to a SHIP Counselor when more assistance was needed.

The SHIP work around Part D will continue and will now focus more on the Medicare-only population that has not yet signed up with a plan. The Counselors will also need to assist people to find a new plan if their current plan goes out of business or the beneficiary simply does not feel that he/she is getting good service from the plan. We anticipate that there will be more calls for assistance when the open enrollment period starts again on November 15, 2006, and into the future as people age, or become disabled and prepare to enroll in Medicare for the first time.

Emergency Management and Planning

Many hard lessons were learned as a result of Hurricane Katrina in 2005, one of the worst natural disasters in American history. Older adults and people with disabilities were disproportionately impacted by this event. Of the 824 deaths identified as of February, 2006, 39% were people age 75 or older, including 154 deaths in people in nursing facilities and hospitals.[cxx] With the lessons of Hurricane Katrina still fresh on our minds, we are also recognize that any number of emergencies, natural, biological and man-made, could occur at any time. Whether a hurricane, an ice storm, an act of terror or a pandemic flu, we have a responsibility to prepare now so that our ability to manage in an emergency is strong, and so that older adults, people with disabilities and those without access to transportation will not face the same conditions they did during Katrina.

Within Vermont State government, efforts are well underway to ensure that all Vermonters are as prepared as possible, and that the systems are in place to manage emergencies, regardless of the nature of the emergency. Department staff participates actively in these efforts, including assisting in the development of a plan to emergency management and individuals who may require specific accommodations due to a particular health or medical condition, or other needs. This plan has been presented to the Commissioner of VDH, the designated lead agency for managing State Support Function 8 (SSF-8), related to health and medical services in the State's Emergency Operation Plan. Currently, the Department participates on an AHS-wide committee responsible for coordinating the development of emergency management plans within AHS. The committee works closely with the Department of Public Safety's Vermont Emergency Management Unit to ensure that the AHS plans are coordinated with VEM activities and that the roles for each agency or department are clearly defined. This work will also involve the development of the Department's own emergency management plan, outlining the critical functions that are performed by the Department, plans for continuing or maintaining those functions, spelling out the legal authority that the Department has for taking various actions, and identifying staff that could assist in other aspects of managing an emergency. Our work will also require follow-up with a range of community partners to ensure that older Vermonters, people with disabilities and the providers and organizations that support them are involved in local emergency planning

efforts and have their own emergency management plans in place. In July 2006, Department staff participated in the state's largest emergency management exercise, responding to a pandemic flu event over a two week period. This exercise brought together multiple state and local responders to test their preparedness to respond in the event of a large-scale emergency and to identify ways in which the state can improve its ability to manage a real-life emergency.

The Department expects to take a leadership role in emergency management for and with older adults and people with disabilities and recently attended the *2006 Working Conference on Emergency Management and Individuals with Disabilities and the Elderly*. This conference, co-sponsored by the U.S. Department of Health and Human Services and the U.S. Department of Homeland Security, brought together state aging and disability experts with emergency management officials to integrate their work in emergency management planning. From this conference, the Vermont delegation identified a number of actions that can be taken to strengthen emergency management and planning for older adults and people with disabilities, including: 1) involve older adults and people with disabilities, and the organizations with which they work, in emergency management planning now; 2) promote personal emergency preparedness and planning for all Vermonters, including providing specific information and resources to older adults and people with disabilities; and 3) while there will likely be some need for special shelters to accommodate specific needs, every effort should be made to provide the many accommodations that can be made at local, "general population" shelters so that people do not need to be separated from the friends, family and community.

PROGRAMS FUNDED UNDER THE OLDER AMERICANS ACT

The following pages provide an overview of the services funded by Titles III and VII of the Older Americans Act as well as other funds directly administered or linked to the Department of Disabilities, Aging and Independent Living administrative operations.

Title III of the Older Americans Act is a primary funding source for a large portion of the state's services to older Vermonters. In addition to the Department, the state's five AAAs, Vermont Legal Aid and the State Long Term Care Ombudsman Program all benefit from this funding source and are responsible for meeting the intent and purposes of the Act. The OAA focus is on assisting older individuals to remain independent, supporting family caregivers and providing leadership in the development and support of a comprehensive system of long-term care services. The OAA directs the State and its grantees to ensure services reach those individuals with greatest social and economic need, including low-income minorities. In the AAA Area Plan Instructions for Federal Fiscal Years 2007 – 2010 the Department has specified a minimum of 65% of Title III-B (Supportive Services) funds must be expended on access[cxxi], 1% on in-home services and 5% for legal assistance. The goal of establishing these particular minimum proportions that must be spent on the services is to ensure an adequate level of service, while at the same time, permitting AAA optimal flexibility to plan services and address the needs identified through their regional assessment and planning processes.

TITLE III SERVICES

Information, Referral and Assistance

Long viewed as the gateway to accessing essential information and resources, the AAA Information, Referral and Assistance Program provides comprehensive and objective information to older Vermonters and family caregivers so that they can make informed choices about the options available to help them to remain independent and/or to continue in their caregiving role. Ready access to information, referral and assistance on a broad array of topics, from community meals programs, to transportation to respite services, is available by calling the statewide toll-free Senior HelpLine. The Senior HelpLine automatically connects callers to the AAAs providing services in the region from which they are calling. Since its expansion in 1995 to all five AAAs regions of the State, HelpLine utilization has grown significantly from year to year. In Federal Fiscal Year 2005, the five AAA fielded 32,962 requests for I/R/A from or on behalf of older Vermonters and family caregivers, representing an increase of more than 44% compared to Federal Fiscal Year 2001. In Federal Fiscal Year 2005, calls increased sharply at the end of the year as Medicare beneficiaries utilized the Senior HelpLine to access information and assistance related to Medicare Part D, and to access the assistance of SHIP counselors, if needed.

To date, three of the five AAAs have purchased and installed I&A software to assist in managing and updating information about services and resources, and providing valuable data about I/R/A services provided. Through the ADRC project, even greater focus will be placed on expanding

and enhancing the I/R/A services provided by the AAAs, including purchasing and installing I&A software for the two remaining AAAs without this resource, exploring opportunities to make the data entry and maintenance of the resource data as efficient and effective as possible across all five AAAs and providing training to staff in the use of the software, as well as broader training in providing services to older adults and other populations.

Over the past few years, AAA I&A Specialists have also been active participants in the statewide coalition that helped to plan and implement the Vermont 2-1-1 Information and Referral Service. Currently, calls to Vermont 2-1-1 from individuals seeking information and assistance related to aging and family caregiving are referred to the Senior HelpLine for more specialized I/R/A. In addition, under Vermont's first Real Choice System Change Grant that was awarded in Federal Fiscal Year 2003, concentrated focus was placed on improving and coordinating mechanisms across the I/R/A systems for older adults and younger people with disabilities to provide consumers with easy access to independent, consistent and accurate information, and assistance in navigating the service delivery system. A task force was formed to examine I/R/A functions across the various delivery systems. This work resulted in the development of core I/R/A standards and a self-assessment process that could be used by agencies to assess their capacity to provide I/R/A and to identify opportunities for improvement. Much of the work from the Real Choices grant laid the groundwork for the Department's ADRC project and has also led to the creation of the new I/R/A Statewide Coordinating Council. The goal of the council is to develop a coordinated, seamless I/R/A system built on partnerships among the 2-1-1 system and other I/R/A providers in Vermont.[cxxii] The Department and AAAs will be involved in this council as we work with other key organizations throughout Vermont to achieve this goal.

Finally, the Real Choices grant also provided essential funding to ensure that older Vermonters, people with disabilities and their families are able to access the information necessary for them to make informed decisions about long-term care services through the development and implementation of a public communication plan that helped to publicize and promote the Senior HelpLine and the "I-Line" at the Vermont Center for Independent Living. As we begin the development of ADRC in Vermont, additional efforts will focus on helping to market ADRC, with the AAA I/R/A Programs a key component of this effort.

Objectives

1. Increase by 5% per year the number of calls made to the I/R/A Program from the Federal Fiscal Year 2005 level of 36,962 (31,816 related to older Vermonters, 1,146 from family caregivers).
2. Purchase, install, and fully utilize across all five AAA professionally designed I&A software to manage resource and program utilization data, including development and implementation of methods to make the management and maintenance of resource data as efficient and effective as possible across all 5 AAAs.
3. Participate in efforts to develop a coordinated, seamless I/R/A system built on partnerships among the 2-1-1 system and other I/R/A providers in Vermont.
4. Develop the capacity for technical assistance and information sharing among I/R/A staff at the AAAs and other I/R/A, ADRCs and other providers.

Case Management Services
Service Coordination and Advocacy

Case managers play a vital role in helping older Vermonters and their families build upon their strengths, garner new resources, and develop a solid plan for achieving the goal of maximum independence. Over the years, the Department has worked closely with the AAAs and the HHA network, to develop a comprehensive approach to the provision of case management services. In Federal Fiscal Year 2005 AAAs provided 67,935 units of case management to 8,565 older Vermonters, roughly a 20.5% increase from the 56,396 units of service provided and a 5% increase from the 8,160 older Vermonters who received case management in Federal Fiscal Year 2001.

In Federal Fiscal Year 2002, the Department, working in collaboration with the AAAs and HHAs, developed and implemented Case Management Standards and Certification Procedures. The Standards and Certification Procedures apply not only to case management provided under the OAA, but also to those provided through the Choices for Care Program. Currently there are over 75 certified case managers employed by the AAAs and HHAs providing services throughout Vermont.

The Department has also maintained a commitment to ensuring that case managers have opportunities for professional growth and receive the training necessary to provide high quality case management, by providing financial support to the Central Vermont Council on Aging to develop and implement a comprehensive case management orientation and training plan. In addition to the Department's contribution, the AAA and HHA also provide the financial support needed to ensure a strong case management training program. Training topics are reviewed and adjusted annually to respond to the training needs of case managers. As the Department implements its new comprehensive Quality Management Plan, it is expected that information gleaned from the quality management reviews will be incorporated into future case management training sessions.

In addition, through the reorganization of the Department, the Division of Disability and Aging Services now administers OAA services, Choices for Care, as well as services for people with developmental disabilities and traumatic brain injuries. Case management, or service coordination, are also provided to participants in these programs. This presents an opportunity to learn from one another and to explore opportunities to collaborate, learn about different approaches to providing case management, and/or share resources. Training provides a good example of how certain functions may interrelate; although there may be certain expertise required to work with a particular group of individuals, there are also a number of training topics that could benefit case managers and service coordinators regardless of the program through which they provide services.

Objectives

1. The Department projects an increase of 5% of individuals served and 10% of services provided over the course of the State Plan on Aging. As a result of the implementation of Choices for Care, it is anticipated that AAA will provide increased case management to a

growing number of people who choose to receive long-term care services in their homes and the community. Because the implementation of Choices for Care is still new, it is difficult to predict precisely the increased level of services based on previous years.
2. Conduct on-site quality management reviews of case management services, by service region and with individual case management agencies; and provide on-site technical assistance, evaluation and follow up to providers of case management services.
3. Provide information and data to case management agencies that will allow them to monitor and continue to develop the quality of their case management services.
4. Update and revise the Case Management Standards and Certification Procedures to reflect current expectations for case managers and case management agencies.
5. Continue to provide support for orientation of new and on-going training and development for case managers.

Nutrition Services

Vermont's Nutrition Program provides nourishing meals, nutrition screening, and nutrition education to older Vermonters in both community and home-based settings. A substantial number of participants, especially those receiving home delivered meals, are at nutritional risk due to limited income, disability and/or isolation. The Nutrition Program contributes to the overall physical and emotional health and well-being of all participants by: serving meals that contribute to nutritional needs; providing health promotion and disease prevention information and services; providing opportunities for social interaction; and facilitating access to referral information and other services.

Nutrition program growth remains steady. Although the frequency of new meal site openings has slowed, expansion of home delivered meals (HDM) service days and delivery routes continues. In Federal Fiscal Year 2005, Vermont served 631,344 HDM, an increase of 0.03% from Federal Fiscal Year 2004 (629,143 HDM). At the same time, the number of community meals declined by 5%; from 404,483 in Federal Fiscal Year 2004 to 384,459 in Federal Fiscal Year 2005. Home delivered meals accounted for 62% of Vermont's 1,015,803 meals served in Federal Fiscal Year 2005, continuing the trend whereby an increasingly frail, homebound population is served by the program. As the demand for these services outstrips current funding, many programs now face the prospect of a waiting list for HDM service.

Over the past few years, the Department has collaborated with the AAA Nutrition Program Directors and local providers, the Vermont Department of Health and the University of Vermont Extension on a number of initiatives. With the AAA Nutrition Program staff and local providers, these include: in-service training on the use of the *Vermont Senior Nutrition Program: Program Management Handbook*; in-service training on safe food handling; diabetes management as it relates to meal preparation; monthly meetings and a day-long planning retreat with the Nutrition Program Directors; and distribution of a quarterly newsletter to providers. For the past two years, the Department has also convened an annual day-long planning meeting with AAA Nutrition Program Directors and the AAA Consulting Nutritionists. Collaboration with the Vermont Department of Health and the University of Vermont Extension is summarized in the Health Promotion and Disease Prevention section of this plan.

For the next four years, the following objectives will be developed and implemented in close collaboration with the AAA Nutrition Program staff:

Objectives

1. Provide on-going monthly information to AAA Nutrition Program staff and/or local nutrition service providers on issues related to implementation of the OAA including: Nutrition Program standards, menu planning, food preparation techniques for modified and special diets, safe food handling, and other relevant nutrition and health promotion topics.
2. Distribute a newly revised edition of the *Vermont Senior Nutrition Program: Program Management Handbook* (final copy to be ready for distribution in the summer of 2006); and provide in-service training to providers before the start of Federal Fiscal Year 2007.
3. Draft and complete revisions to Vermont's Older Americans Act Nutrition Program Policies and Procedures.
4. Draft and implement a Department protocol and tool for monitoring the AAA management of the OAA Nutrition Program.
5. Develop a HDM waiting list policy that prioritizes and targets services to elders in greatest economic and/or social need.
6. Distribute and provide training on the Department's Nutrition Education Plan for the OAA Nutrition Program. Two toolkits of ready-to-use nutrition education materials will be distributed: a professional version to the AAA Consulting Nutritionists; and a lay person version to the Nutrition Program Directors and larger community meal sites.
7. Ensure the quality of delivery of meals and other nutrition services through the use of performance standards, outcome based measurements and quality assurance protocols.
8. Provide technical assistance to the AAA Consulting Nutritionists.
9. Provide on-going technical assistance in the collection of State Program Reporting data to support reporting, advocacy and targeting of resources.
10. Become a more active partner in the *You Can! Steps to Healthier Aging* Initiative.

Health Promotion and Disease Prevention

Acting on the knowledge that lifestyle choices have a greater impact than heredity on health, functional capacity, quality of life and independence, the Department continues its active involvement with initiatives that promote healthy aging and independent living. Based on previous work of the Successful Aging and Independent Living (SAIL) Task Force (initiative ended in May 2005), four outcomes form the basis of most health promotion and disease prevention efforts by the Department and the AAA. Those outcomes are, older Vermonters and adults with disabilities: (1) have a low risk of disease, disease-related disability, injury and secondary health conditions; (2) maintain high physical and mental function; (3) are as engaged in life as they prefer; (4) live with dignity and independence in the setting they prefer. The Department tracks progress on many indicators for each outcome, and compiles the data in its *Vermont SAIL Report*. Many of the indicators coincide with the goals outlined in *Healthy Vermonters 2010*, the Department of Health blueprint for improving public health over the next

decade. The second *Vermont SAIL Report* was released in May 2005. Although the SAIL Task Force no longer exists, the Department is channeling its statewide healthy aging efforts through the newly convened Governor's Commission on Healthy Aging (see description in *Special Projects and Initiatives* section of this plan).

The Department collaborates with the Vermont Department of Health (VDH) on a number of health promotion and disease prevention initiatives, including, but not limited to: the Self-Management and Healthy Communities workgroups of the Blueprint for Health. The Health Department is also the lead agency for managing efforts to immunize Vermont citizens, particularly for influenza and pneumonia; and the Department, HHAs, AAAs and SHIP are all involved in promoting immunization for older Vermonters. HHAs host numerous clinics throughout the State and provide focused outreach to consumers of their services. The AAAs and SHIP help to publicize the availability of vaccines and provide details about how older Vermonters can be immunized. The Department is also an active participant on the Vermont Osteoporosis Task Force. Collaboration with the University of Vermont (UVM) remains strong. We continue to serve as mentors/supervisors for Human Nutrition students enrolled in the Community Services Practicum at the UVM Department of Nutritional Sciences. Additionally, the Department works collaboratively with UVM Extension and the Vermont Department of Health on a diabetes management program, *Dining with Diabetes* and a newly developed pre-diabetes class. The Department is an active member of a newly formed State Nutrition Action Plan, or SNAP, committee. That group, comprised of key nutrition professionals from agencies across Vermont, is working on developing unified nutrition and health messages across the lifespan. The overarching message is *Eat for Health*. Lastly, the Department is a member of the Centers for Disease Control's Chronic Disease Directors Healthy Aging group.

Objectives

1. Advocate for and promote evidence-based practice in statewide nutrition and physical activity initiatives.
2. Continue active participation on the Vermont Blueprint for Health workgroups and Executive Committee.
3. Support the Governor's Commission on Healthy Aging.
4. Continue tracking data relating to healthy aging and compile them in a report for distribution (similar to the *Vermont SAIL Report*).
5. Report on the Senior Center Earmark project (see *Special Projects and Initiatives* section) and help to spread best practices.
6. Update and renew the Memo of Understanding with the Vermont Department of Health to foster collaboration on work that promotes healthy aging.
7. Continue collaboration with the Vermont Department of Health, Vermont Osteoporosis Task Force, UVM, AAA, long-term care coalitions and other health promotion groups on initiatives that provide information and services that promote successful aging and independent living, including initiatives focused on falls prevention and reducing obesity in older Vermonters.
8. Continue efforts to confirm and influence the coordinated vaccination of older Vermonters, particularly for influenza and pneumonia.

National Family Caregivers Support Program and Related Programs

The NFCSP is an important source of assistance for Vermont's family caregivers. This program, funded by Title IIIE of the Older American's Act, is designed to provide services and support to family and non-family caregivers of any age to persons age 60, or older or a family caregiver age 60 or older, who is providing care to a child under age 18. Priority is given to older individuals with the greatest social and economic need.

The NFCSP offers five basic services for family caregivers, including: 1) information to caregivers about available services; 2) assistance to caregivers in gaining access to supportive services; 3) individual counseling, support groups and caregiver training to assist caregivers in making decisions and solving problems relating to their caregiver role; 4) respite to provide temporary relief from caregiving responsibilities; and 5) supplemental services to meet caregiver needs.

In Federal Fiscal Year 05, the Department developed and implemented new NFCSP reporting procedures to comply with new reporting requirements issued by the AoA. Since this was the first year of implementing the procedures, the Department will work with the AAAs to review the procedures and make any revisions necessary to ensure that the procedures are clear and result in the accurate reporting of program statistics. During Federal Fiscal Year 2005, utilization and expenditures for Vermont's NFCSP were as follows:

	Caregiver Support Categories	Title III-E Expenditures (Federal $)	Total Service Expenditures (all sources)	Number of Caregivers Served*
1.	Counseling/Support Groups/Caregiver Training	$18,887.00	$25,616.00	62
2.	Respite Care	$131,902.00	$174,781.00	335
3.	Supplemental Services	$1,800.00	$2,422.00	3
4.	Access Assistance	$153,680.00	$200,219.00	2,370
5.	Information Services	$100,027.00	$142,230.00	144,865
	Totals	$406,296.00	$545,268.00	147,635

**The number of caregivers served may be duplicated across categories of services.*

At the local level, Vermont's AAAs manage the NFCSP program, however, there is considerable variability between agencies as to which services are offered. Whereas some AAAs have focused primarily on providing information and referral services, others have used NFCSP funding to provide a range of services. Efforts are underway to improve services for Vermont's family caregivers by identifying the specific needs and strengths of family caregivers, identifying gaps in services in each geographic region, and developing area plans that will prioritize how NFCSP resources are provided to respond to caregiver needs.

In addition to NFCSP services, Vermont's Dementia Respite Program is recognized as an important source of support for individuals with dementia and their family caregivers. The program was launched as a pilot project serving 40 households in 1998. Since July 2002,

program participation has increased by an average of 9.4% per year. In State Fiscal Year 2005, three hundred and ninety five households benefited from the program.

Population projections indicate that the number of individuals with dementia is expected to increase to 13,000 by 2025 in Vermont.[cxxiii] Given that family members provide more than 50% of caregiving functions[cxxiv] it is expected that the number of Vermont households needing assistance will continue to grow in coming years. Family caregiving is both physically and psychologically demanding, and the need for family caregivers to obtain relief from caregiving responsibilities is essential to their physical and mental health. Numerous testimonials from family caregivers who have obtained support through the Dementia Respite Program, indicate that this assistance allowed them to participate in support groups and wellness activities that helped them maintain their caregiving role, and delayed or prevented nursing facility admission of their family member with dementia.

The Dementia Respite program is currently funded through Vermont's General Fund and the Administration on Aging Alzheimer's Demonstration Grant to States (ADDGS, please see additional information in the *Special Projects and Initiatives* section). The program is managed by Vermont's five AAAs Dementia Respite Coordinators. During State Fiscal Year 2005, families were referred to the program primarily by other AAA staff. Home Health Agencies and Adult Day centers were also frequent referral sources. With the recent implementation of the ADDGS Caregiver Bridges pilot project, and its goal of developing linkages between primary care physicians' practices, community mental health centers, and other care providers, it is expected that more referrals for Dementia Respite grants will come from physicians and Elder Care clinicians in the future.

To be eligible for Dementia Respite grants, caregivers must be providing care to Vermont residents with a physician's diagnosis of Alzheimer's Disease or other dementia, and who meet financial eligibility criteria. Priority is given to those who are ineligible for other programs, and as such, those receiving services through Choices for Care Medicaid Waiver Program, the Attendant Services Program, or respite services through the NFCSP are ineligible for Dementia Respite funds. The amount of each award is determined on a case-by-case basis however, the maximum amount of funding per household is limited to $3,000 annually. Recipients may re-apply for a respite grant each year. One of the most highly regarded benefits of the program is the flexibility that recipients have for use of the funds. In State Fiscal Year 2005, the most common use of dementia respite funds were to cover the cost of home-based respite care, adult day services, and chore or homemaker services.

In addition to receiving financial assistance, respite beneficiaries also receive information from Dementia Respite Coordinators about local resources such as support groups and wellness programs. In previous years, dementia respite grant recipients were also referred to the Vermont Chapter of the Alzheimer's Association for dementia caregiver training. The Vermont/New Hampshire Chapter of the Alzheimer's Association is currently unable to provide such training; however, Chapter staff have expressed an interest in re-establishing these activities.

In addition, the Department plans to integrate existing programs with other initiatives such as the ADRCs that are currently under development. ADRCs will provide family caregivers and other

consumers with improved access to services and resources. Moreover, family caregivers will be able to utilize the ADRCs to readily obtain comprehensive information about physical health issues, dementia and family caregiving. The importance of tailoring services to meet the needs of individuals is also receiving increased attention. The Department is implementing the Flexible Choices program in conjunction with the Choices for Care Program. Flexible Choices will provide Choices for Care participants and/or their family caregivers with the option of using an allotment of funds to purchase goods or services that will support their well-being at home. By combining these new initiatives with the existing Dementia Respite and FCS programs, the Department will be in a better position to meet its goal of assisting older Vermonters to remain as independent as possible and supporting family caregivers to continue in this essential role.

Objectives

1. Expand and improve services for Vermont's growing aging population by integrating existing programs with other DAIL initiatives.
2. Provide all five categories of NFCSP services in each AAA planning and service area and increase the amount of services provided and number of family caregivers served through the NFCSP. With Federal Fiscal Year 2005 providing baseline data, we project a 5% increase in services and caregivers over the course of this State Plan on Aging.
3. Identify and address the needs of family caregivers in different geographic regions.
4. Recognize individual variability among older Vermonters and their family caregivers by providing consumers with greater flexibility in choosing services.
5. Collaborate with the VT/NH Alzheimer's Association to re-establish their dementia caregiver training programs in Vermont.
6. Collaborate with AAAs and other community partners to support family caregivers.
7. Provide technical assistance to AAAs in administering, developing and reporting data related to family caregiver support services.

TITLE VII SERVICES – ELDER RIGHTS SERVICES

Adult Protective Services

Vermont's Adult Protective Services (APS) program operates within the Department's Division of Licensing and Protection. APS receives reports and investigates allegations of abuse, neglect and exploitation of vulnerable adults residing in a variety of settings. Six full-time field investigators conduct community-based investigations. Nurse survey staff conduct APS investigations in licensed/certified facilities.

The program's operating philosophy supports client directed services. There is a strong belief that vulnerable adults can and should make their own decisions and choices as long as they have the capacity to do so.

In State Fiscal Year 2006 APS received 1,530 reports of alleged abuse, neglect and/or exploitation. APS activities include intake, service referral, screening, case consultation,

technical assistance, investigation and protective services. Protective services may include assistance with letters of unlawful trespass, restraining orders, referral for guardianship, referral to community services and collaboration with law enforcement personnel on joint civil/criminal investigations on behalf of vulnerable adults. Each year APS provides hundreds of case consultations and referrals, to ensure that vulnerable adults are linked to community service providers who can help them remain safe and secure. APS also accepts reports of self-neglecting adults who are under 60 years of age and are vulnerable adults. Reports of older adult self-neglect are referred directly to one of the state's five AAAs.

The APS Program maintains Vermont's Adult Abuse Registry. When an individual is found to have abused, neglected or exploited a vulnerable adult, that person's name is added to the Abuse Registry. Employers may check the Registry prior to offering an applicant employment, thus screening out people who have a history of abusing vulnerable adults. Last year APS conducted over 30,000 Abuse Registry checks for Vermont employers. Additionally, in April 2006 DAIL implemented a consistent department-wide background check policy that requires all organizations that receive funding via the department to check not only the adult abuse registry, but the state's child abuse registry, the Vermont Crime Information Center, the federal Office of the Inspector General Medicaid exclusion list of the Department of Health and Human Services and a motor vehicle check for those individuals transporting consumers.

Prevention of adult abuse is an important part of the APS mission, and one of the most efficient and effective prevention tools is community education. In State Fiscal Year 2005, APS provided in-service education to 1,059 people through 40 on-site education programs. These efforts will continue to expand in years to come.

APS interventions result in many successful outcomes for adult victims of abuse. Frequently these successes are the result of close collaboration with community service providers, especially AAAs, HHAs, licensed facilities, public guardians and community developmental and mental health providers. The APS Program could not do its job without these cooperative and collaborative partnerships.

Objectives

1. Expand community education relating to abuse reporting, prevention and interventions for service providers, long-term care providers, health care students, law enforcement, financial institutions and citizen groups to strengthen community effectiveness in helping to address vulnerable adult abuse in Vermont.
2. Develop a system for emergency substitute care to vulnerable adults in response to family caregiver abuse situations.
3. Establish an APS Focus Group to maintain a high level of community interest and input involving adult abuse prevention activities.
4. Produce an annual report to inform the legislature and the public of the scope and nature of vulnerable adult abuse in Vermont.
5. Conduct a detailed study of APS closed cases to develop profiles of high-risk individuals and environments, and to identify and target effective interventions around abuse prevention.

6. Develop working agreements with law enforcement and financial institutions to improve communication and cooperation in identifying and resolving both criminal and civil issues of abuse, neglect and exploitation of vulnerable adults.

Legal Assistance

The Department provides Title III-B funding to the five AAAs, who in turn purchase legal services from two providers on behalf of older Vermonters within their service regions. Four AAAs have a contract with Vermont Legal Aid, Inc. to provide advice, advocacy, and legal representation through the Senior Citizens Law Project (SCLP). The SCLP employs approximately 4.6 full-time equivalent employees, with a full- or part-time staff attorney dedicated to each of the four AAA service regions. The fifth AAA (Northeastern Vermont Area Agency on Aging) has elected to use its Title III-B allocation to contract with a private firm for advice and legal representation for individual clients. Four AAAs have a contract with Vermont Legal Aid, Inc. to provide advice and legal representation to individual clients and advocacy on systemic issues, as well as training and technical support to AAA staff, and advice on matters within its expertise to private attorneys, through SCLP. The fifth AAA has a contract with the SCLP for advocacy on systemic issues and to provide technical assistance to the contract attorneys and advice to private attorneys within their service area. The legal services providers prioritize their intake and caseload to ensure that services are targeted to clients in greatest social and economic need.

High priority cases generally addressed by the legal services providers include eligibility and coverage issues involving public benefits, access to health care, planning for long-term care and for incapacity, financial exploitation, landlord/tenant and other housing issues, guardianship and protecting the civil rights of elders living in long-term care institutions. Other lower priority cases are typically referred to the Legal Service Law Line of Vermont, a Legal Services Corporation-funded provider of telephone legal advice, or to private attorneys who have agreed to provide representation for free or at a reduced rate through a referral program maintained by the SCLP.

Legal service providers provide ongoing technical assistance and backup to the network of case managers/advocates employed by the five AAAs. These case managers provide many of the referrals to the providers and often work closely with attorneys on cases involving guardianship, consumer protection and public benefit entitlement cases.

The Little Legal Handbook for Older Vermonters, published by the Champlain Valley Agency on Aging on behalf of the five AAAs, with the assistance of Vermont Legal Aid and the Elder Law Committee of the Vermont Bar Association, is a valuable and popular resource for older Vermonters and their families. It was updated and reprinted in 2002.

Objectives

1. Provide high quality advice and legal representation to Vermonters age 60 and older who are in the greatest social and economic need.

2. Identify and provide advocacy on systemic issues such as access to health care, financial exploitation, guardianship and the civil rights of institutionalized elders.
3. Ensure the coordination of services with other legal services providers, including Legal Services Law Line, the Office of Health Care Ombudsman, the Vermont Long-Term Care Ombudsman Project and other projects of Vermont Legal Aid, Inc., and with private attorneys.
4. Provide leadership in the practice of elder law through active participation in the Elder Law Committee of the Vermont Bar Association and other local and statewide groups.
5. Provide training and technical assistance to AAA staff, private attorneys, and consumers.
6. Increase the number of private attorneys available to represent older Vermonters in areas such as long-term care planning and public benefit programs and improve their knowledge about elder legal issues through seminars and other continuing education opportunities, and recruit additional private attorneys to provide low-cost legal services to older Vermonters to expand the number of older Vermonters served beyond the SCLP target of 700 cases per year.
7. Participate in statewide focus groups established by the Department as part of the AHS Adult Abuse Prevention Initiative to address issues of elder abuse, neglect and financial exploitation.
8. Participate in legislative efforts to amend the guardianship statute and other legislation that will have an impact on older Vermonters.
9. Review *The Guidebook for Employing a Caregiver* for its applicability to older Vermonters employing their own caregivers.

Office of Long Term Care Ombudsman

The Department contracts with Vermont Legal Aid, Inc. to operate the Vermont Ombudsman Project (VOP) - a statewide long-term care ombudsman program that fulfills all of the advocacy requirements of Title VII, Chapter 2 of the Older Americans Act. Currently, there is one full-time State Ombudsman who supervises six full-time, regional ombudsmen plus a volunteer coordinator. In addition to paid staff, the project utilizes 14 certified volunteers and currently has 6 additional volunteers in training.

In 2005, the Vermont Legislature expanded ombudsmen's duties and responsibilities. Ombudsmen now advocate for all individuals who receive long-term care services under Choices for Care. Therefore, in addition to advocating for residents of nursing facilities and residential care homes, ombudsmen now have the authority to respond to complaints on behalf of individuals receiving home-based care services through Choices for Care.

The VOP received additional funding through Choices for Care to hire two new staff. The six regional ombudsmen will be cross-trained to handle complaints originating from nursing facilities and residential care homes as well as home-based complaints. Under its contract with the state, the project will dedicate the equivalent of two full-time staff to investigate and resolve home based complaints. A full-time volunteer coordinator will continue to recruit and train new volunteers who will help ensure that long-term care facility residents throughout the state have timely access to quality ombudsman services. The paid staff handle the cases and complaints

which require a higher level of training or expertise, while many of the simpler problems experienced by residents, (most of which are susceptible to quick resolution) are handled by volunteers in consultation with paid Ombudsman staff. Volunteers will not be responsible for handling home-based complaints.

The number of nursing facility beds in Vermont is declining. With Choices for Care, more people now have the opportunity to receive services in a home- or community-based setting. Although this is a positive change in the way long-term services are provided, it creates new challenges for the state and the ombudsman program. As the shift to community-based care increases, it is likely that more facilities will close. It is critical that there be safeguards in place to protect the health, safety and welfare of the residents during closures, and that there be a well-designed relocation plan in place that informs residents and their families of their options early on in the process and helps them find appropriate alternative placements. In addition, as more vulnerable individuals receive nursing facility level of care in home- and community-based settings, it is important to make sure that the health, safety and welfare of these individuals are also protected.

Objectives

1. Continue to recruit and train volunteers to maximize ombudsman services to residents in nursing facilities and residential care homes throughout the state.
2. Explore ways to promote person-centered services in both facility and home- and community- based settings.
3. Implement safeguards through legislation, regulation or written protocols that will protect residents when facilities close.
4. Respond to 550 complaints, provide 250 consultations to facilities or individuals; and conduct 100 non-complaint resident visits.

Office of Public Guardian

Vermont has an Office of Public Guardian (OPG) which provides guardianship services to older Vermonters and individuals with developmental disabilities who have been determined by the Family or Probate Court to be in need of guardianship supports to live safely and protect them from violations of their human and civil rights. A public guardian is appointed when there is no one else willing or suitable to serve as guardian.

This unified OPG was formed as part of the reorganization of the Agency of Human Services. The combined program has a staff of 25 public guardians; 5 specializing in supporting 53 individuals aged 60 and over (based on SFY ’05 data), and 20 specializing in supporting 554 individuals with developmental disabilities. In the past, guardianship to older Vermonters was limited by statute, but the increase in staff due to the blending of guardianship programs will enable a greater number of older Vermonters to receive the necessary guardianship supports. In addition to guardianship, OPG provides case management services, oversight and service coordination to people committed to the custody of the commissioner, support to private guardians, family reunification, and representative payee services. In addition to the numbers

above, there are an additional 50 individuals receiving case management or other specialized supports, and over 300 receiving representative payee services through the program.

The program's Public Guardians work with individuals living throughout Vermont. They make regular home visits to the people they serve and take part in planning and monitoring their care, supports and living situations. They make sure people have the supports needed to be safe and protected from abuse, neglect and exploitation. They help people to make their wishes and needs known, to become more independent, and to make connections with friends and family. As medical guardians, Public Guardians provide active medical advocacy and coordination, and make decisions about medical treatment. Public Guardians are available for emergencies 24-hours a day.

Outreach, Counseling and Assistance

Vermont's five AAAs provide case management, advocacy, outreach and assistance to thousands of older Vermonters each year. The AAAs service delivery system is designed to serve all older Vermonters but especially those in the greatest need of assistance due to economic hardship, isolation, increased frailty, declining health, and other factors that negatively impact well-being. The AAAs' primary goal is to help older Vermonters live as independently as possible in the settings they prefer.

There are approximately 75 certified AAA Case Managers [cxxv] who work with older Vermonters, providing outreach, counseling and assistance that is usually developed through a formal plan of care. In addition, approximately 20 Advocate staff work with older Vermonters on a more short-term basis, offering information, assistance and short term help to those who do not need longer term case management support. Each AAA also employs staff that are Outreach Specialists, who focus on the Medicaid, Fuel Assistance and Food Stamps programs. Regardless of the 'type' of AAA staff involved, all are skilled and knowledgeable in the field of aging.

In 1999, the Department began a collaborative effort to assist the AAAs in building a qualified case management support system through a standardized case management certification program. Our goal was to ensure consistency and quality in provision of case management services statewide, especially in provision of OAA and Medicaid Waiver services. Through a grant agreement with the Central Vermont Council on Aging (CVCOA) the Department assists in and supports the training program development and implementation on topics that include: public benefit program such as Community and Long Term Care Medicaid; elder rights; abuse, neglect, self-neglect and exploitation; elder mental health topics, etc. Each year the Department offers two certification exams to prospective case managers and in 2002 State General Funds were provided to establish a standardized training curriculum open to all AAA and HHA case management personnel. It is designed to build upon and enhance the core competencies of case management staff.

Counseling, outreach and assistance services are provided by the AAA staff in close collaboration with legal services providers, state agencies administering public benefits

programs, home health care providers, and other community-based organizations. For further information about related services please refer to the section on Case Management.

Objectives: Please refer to the objectives outlined for Information/Referral/Assistance and Case Management Services earlier in this plan.

A Note about Competition in the Provision of OAA Services: As stated in the *AoA Guidance on the Development and Submission of State Plans and Intrastate Funding Formulas*, competition in financing and providing services is an important element that can influence not only the cost of care, but the quality of services. Both at the State and local level, competitive procurement procedures are followed when contracting for services to ensure that contracted services are cost-effective and of high quality. At the State level, State Bulletin 3.5 provides guidance to the Department regarding contract procedures to which all State agencies must adhere. In addition, the Area Plans developed by the AAAs include assurances that specific federal and state requirements will be followed, including those related to procurement and contracting for services.

PROGRAMS FUNDED WITH OTHER RESOURCES
(and/or in conjunction with OAA funding)

Choices for Care

The goal of this program is to improve access to a range of community-based long-term care options for those individuals who require nursing facility level of care. In October 2005 the Department received permission from the Centers for Medicare and Medicaid Services to operate an 1115 demonstration waiver. This waiver eliminates the institutional bias toward nursing facility care and will allow the state to serve more individuals. Participants will be able to choose their long-term care settings based on their preferences and assessed needs, rather than waiting for care if they preferred a home- or community-based setting. This waiver now includes all long-term care settings: nursing facilities, ERCs and home settings.

Services provided under Choices for Care include case management, personal care, adult day services, respite care, companion care, personal emergency response systems, assistive devices/home modifications, Enhanced Residential Care and nursing facility care. The program includes consumer-directed and surrogate-directed service options which now represent approximately 65% of all personal care, respite care, and companion services that are provided. See also the previous section on PACE, another option under Choices for Care, anticipated to be available in at least one region of the State by the fall of 2006.

A major shift in Vermont's long-term care program occurred with the hiring of 12 registered nurses, regionally co-located with the financial eligibility workers in the Department for Children and Families. The intent is to strengthen collaboration between the two departments responsible for financial eligibility and clinical eligibility determinations; and to reduce the time

between application, enrollment, and the initial service delivery. The AAAs have played a significant role in helping the Department expand this program, and provide case management services to more than 50% of participating individuals. HHAs have also played a significant role in the expansion of the program, providing case management, personal care attendant services, and other related services.

Objectives

1. Continue to shift the balance from nursing facility to home- and community-based services by increasing the percentage of long-term care recipients who receive home- and community-based services.
2. Enhance Choices for Care by allowing spouses to be reimbursed for providing personal care services.
3. Implement Flexible Choices (also known as 'cash and counseling') as another service delivery option within Choices for Care. (For more information on Flexible Choices, please see the description in the Special Projects and Initiatives Section of this State Plan on Aging.)
4. Reimbursement to Enhanced Residential Care homes for bed hold leave days to avoid loss income and of residence when an individual has to be in the hospital or nursing facility for short periods.
5. Develop adult family care as another option within Choices for Care.
6. Implement PACE as a service delivery option within Choices for Care.

State Health Insurance Assistance Program (SHIP)

The Department is the State grantee for the CMS State Health Insurance Assistance Program (SHIP), a program designed to inform, educate and assist older Vermonters in applying to Medicare and other insurance programs. We subcontract statewide administration of the SHIP to the Northeastern Vermont Area Agency on Aging (NEVAAA), which operates SHIP in Vermont's three northeastern counties. NEVAAA also subcontracts with their sister AAAs to provide statewide SHIP services. Local SHIP Coordinators oversee day-to-day operations, respond to requests for assistance from older Vermonters, people with disabilities, family members, and agencies, and recruit volunteers to assist in providing direct service. The Department provides a small amount of State General Fund as local match for SHIP operations and during this current fiscal year was a leader in supporting the AAAs successful request for General Fund assistance from the State Legislature in the amount of $400,000 to support implementation of the Medicare Modernization Act (MMA).

The Department maintains a strong partnership with the NEVAAA in the administration of the SHIP. We worked closely with the AAAs to ensure that Vermonters who would have been harmed by the early problems in MMA startup were protected, and received their medications even as the federal program struggled. Vermont was one of several states to revert back to its state pharmacy program when initial start-up of Part D proved problematic. Likewise, we worked closely with the SHIP, CMS, OVHA, and others to ensure that the problems were

worked out so that beneficiaries enrolled in Medicare Part D were able to access their needed prescriptions.

During the past year SHIP staff conducted extensive public education in support of Part D enrollment and implementation, especially during July through December 2005. Along with staff from DAIL, OVHA, the Medicare Patrol Project, and the Office of the Lieutenant Governor, the SHIP provided 346 public presentations to 7,877 people. During this same period they presented on Part D/MMA on 12 cable television stations and ran 34 public service announcements. They staffed booths at 12 community events, reaching an estimated 1,565 people and provided direct enrollment services to 7,270 individuals, 549 couples and 840 caregivers as well as information services to 482 agencies/organizations.[cxxvi]

SHIP's success can be attributed to their ability to build and sustain strong working relationships at the local, state and national level with a diverse group of partners including the Banking, Insurance, Securities and Health Care Administration (BISHCA), the Community of Vermont Elders/Medicare Patrol Project and the State's Health Care Ombudsman Program.

While the challenges presented by the MMA will continue, the Department is most appreciative of SHIP's excellent staff. We recognize that the quality of SHIP service as well as the labor intensive, high demand aspect of this past eight month's work. It is our good fortune to have a seasoned, well-informed and dedicated SHIP staff available statewide during implementation of the MMA. We anticipate a continued need and high demand for SHIP assistance in the months and years to come.

Objectives

1. Support continued effective operations of the SHIP program statewide.
2. Collaborate with SHIP and other partners to ensure continued successful implementation of MMA, including outreach, public education and individualized assistance to Medicare beneficiaries.
3. Encourage the SHIP to expand its cadre of qualified, trained volunteers.

Transportation

Access to transportation services that are flexible and responsive to the varied needs of older adults is critical to the success of many programs available in Vermont. The Department works closely with numerous state and local agencies to ensure that older Vermonters have access to transportation services to maintain independence and promote access to needed services and resources. Transportation is available for those who cannot drive and/or need transportation for a variety of reasons (e.g., to go to a medical appointment, work, shopping, community meal site, adult day program, community activity or meeting). These services are coordinated and provided by local transportation brokers. At the local level, AAAs provide significant support to ensure the availability, quality and coordination of transportation services. As mentioned earlier in this State Plan on Aging, volunteer drivers are an important component of the public

transportation system in Vermont and are active in at least 9 out of 13 Vermont Public Transportation Association networks.

Throughout the State, great emphasis is placed on coordinating transportation services to ensure that services are provided as efficiently and effectively as possible, while at the same time, in a manner that accommodates the special needs of older Vermonters and people with disabilities. With few exceptions, transportation is provided by the local public transit provider through contracts with local community groups for the provision of services, and with funding support from local, State and Federal funds. For the past several years, regional Transportation Advisory Committees, usually convened by the Regional Planning Commission and composed of transportation and human service providers, consumers and advocacy organizations, have met to identify unmet transportation needs of consumers in the region, to plan for the use of limited transportation resources, and to prioritize and manage the use of resources.

Department staff works closely with the AHS Director of Housing and Transportation (a new position created in 2004 as part of the reorganization of the AHS) in efforts to ensure that older Vermonters have access to needed transportation that meets their needs. In 2004, the Department issued a review of the Elders and Persons with Disabilities Transportation Program which identified significant unmet needs for transportation. The summary report offered a number of financial and non-financial recommendations to improve services and to better plan to meet the need into the future. In 2006, the Department convened a small workgroup comprised of representatives from key aging and disability advocacy organizations and agencies, transit providers, and the Vermont Agency of Transportation (VTrans) to provide additional information to the State Legislature regarding the unmet transportation needs of older Vermonters and people with disabilities. In addition, AHS and Department staff have participated in state efforts to implement some of the recommendations included in the Federal United We Ride Initiative, including providing input into the development of the VTrans Statewide Transportation Coordination Plan and the Public Transportation Policy Plan, and providing input and advice to VTrans in the development and submission of grant applications available through this initiative to improve coordination of transportation services in Vermont. Department staff will also participate in the VTrans Elders and Persons with Disabilities Advisory Group.

In September, 2005 the AoA developed a toolkit for State and local planners to help them assess the transportation needs of older adults and to coordinate transportation services for older adults in communities and across the state. While many steps have already been taken in Vermont to assess needs and increase coordination, there is more work to be done, particularly in evaluating the effectiveness of some of the changes that have been made in recent years in terms of increasing mobility for older Vermonters and ensuring efficient delivery of services and identifying further improvements that need to be made. In the future, the AoA toolkit provides several case studies that provide helpful information and will be a useful guide to Vermont's efforts.

Objectives

1. Work collaboratively with VTrans, OVHA (Medicaid Transportation) the Vermont Public Transportation Association, regional planning commissions, AAAs, consumer organizations and other community partners to support the expansion of an efficient and coordinated public transit program that expands access for older Vermonters, maximizes available resources and ensures quality and coordination of service, as well as adequate resources to support such service. This includes AHS participation in statewide United We Ride initiatives.

2. Using the AoA toolkit and other resources, identify new, flexible approaches to transportation, as part of the existing services or as a complement to them, that can accommodate the special needs of older Vermonters and people with disabilities.

3. Encourage all 11 public transportation providers to recruit and support volunteer drivers as a consumer-responsive public transit service and encourage increased education and training of both paid and volunteer drivers as a means of ensuring and improving the quality of services provided.

4. Encourage the implementation of least-restrictive methods of ensuring public safety with older drivers, including safe driving training, screening and correction of health issues affecting safe driving and environmental and design changes to promote safe driving by older Vermonters.

Adult Day Programs

Adult Day Programs (ADPs) represent one of the Department's important initiatives in the expansion of our capacity to serve older Vermonters who need an array of services to support their ability to remain at home. For this population, access to both health and social support systems is essential.

Vermont's ADPs have continued to experience steady growth in both the numbers of persons served and in the quality and amount of services provided. Vermont has 14 certified ADPs, with 17 sites across the state. The number of people served by ADPs has increased 17% between State Fiscal Year 2001 and State Fiscal Year 2005, from 877 to 1,027 and the hourly units of service provided has increased 19.69%, from 368,328 to 440,852. All programs offer supervision of activities of daily living, nutritious meals, therapeutic activities, personal care and professional nursing services. Many programs also have the capacity to provide professional social work; nutrition services; and physical, occupational and speech therapy. ADPs also benefit family caregivers, not only in the knowledge that their family member is receiving professional care and supervision while they are at the program, but in the form of much needed respite, information, and in some cases, support groups, to help them to continue in their family caregiving role.

In an effort to meet the increasing need for adult day services, numerous ADPs have been involved in efforts to either expand their existing space, or move to new space that will accommodate more people. In 2000, 2004 and again in 2005, the State Legislature appropriated one-time funding to support the infrastructure enhancement needs of Vermont's ADPs. These funds have been used to support some of the facility enhancement efforts described above, as well as to install and purchase new equipment important to ensuring quality services.

Medicaid reimbursement for adult day services has increased over time and is slated to increase again in State Fiscal Year 2007. In addition, State General Funds provide programs with funding to help cover a portion of the programs' general operating costs and to help subsidize adult day services for some individuals who need adult day services, but do not have the means to pay. Still, many ADPs struggle to keep up with increasing costs, especially those related to the rising cost of insurance and transportation. For this reason, adult day programs are constantly seeking ways to gain efficiencies in their operations, while at the same time maintaining quality services; and fund raising by ADPs and their governing boards has become more important than ever.

Objectives

1. Carry out on-site quality management reviews of adult day services, by service region and with individual ADPs, to provide on-site technical assistance, evaluation and follow up to adult day services providers.
2. Provide training and technical assistance to the ADPs, individually, and via statewide and/or regional events, to promote the provision of high quality adult day services and to present new approaches and promising practice in providing individualized adult day services.
3. Provide information and data to ADPs to assist in their capacity-building efforts to meet the increasing demand for services, and in monitoring and managing individual ADP performance.
4. Support the ADPs' ability to care for an increasingly frail and disabled population.

Mental Health and Related Services

Vermont's Elder Care Clinician Program (ECCP) was established in State Fiscal Year 2000. The mission of the program is to improve the well being of older adults through outreach mental health services, which increase or maintain quality of life and maximize independence. The ECCP provided services to 486 individuals in State Fiscal Year 2005. Among those served, 74% were female and 26% were males. The most common primary and secondary diagnoses were depressive disorders (58%), anxiety (23%) and adjustment disorders. Nine percent had a diagnosis of dementia and 6% were diagnosed with substance abuse.[cxxvii] It is widely acknowledged that many older adults with mental health issues are not receiving treatment. Older adults are three times less likely than those aged 18-64 to receive outpatient mental health care. Although older adults use mental health services at substantially lower rates than younger age groups, they do benefit from treatment. [cxxviii]

$250,000 in General Funds is provided each year to the AAAs, who in turn, contract with their local Community Mental Health Centers (CMHCs) for the services of the Elder Care Clinicians (ECCs). The funding is matched with Medicaid funds when services are delivered to eligible older Vermonters.

The process for referrals to the ECCP varies across the state. In some regions, referrals are funneled through the local Area Agency on Aging. In other areas, referrals to the program are also received directly from the clients' primary care physicians, hospitals, other CMHC providers and HHAs. Very few clients are self-referred. The majority of clients are seen in their own home, thereby providing access to services for older adults who do not have available transportation or who are uncomfortable seeking services at a mental health center. The length of treatment depends on individual needs. Some clients are seen for a limited number of sessions and then are appropriately referred to other programs and services such as AAA case management. Other clients receive ongoing mental health services through the program.

The majority of clients who require psychotropic medication are served by their primary care physicians. Access to psychiatric services for clients who require more intensive medication management is an ongoing challenge for ECCs due to limited availability of CMHC psychiatrists at most sites and private psychiatrists skilled in working with older adults.

In recent years, ECCs received training on depression, dementia, substance abuse and other mental health issues. Ongoing training on these topics is important so clinicians have information about the latest research on these disorders and treatment interventions. ECCs have also benefited immensely from consultation and discussion of case studies with a geriatric psychiatrist. This consultant position is currently open. Hiring for this position, which will be jointly funded by VDH Division of Mental Health (DMH) and DAIL/DDAS, is vital to maintaining the quality of services provided by the ECCs and recruitment for a geriatric psychiatrist who will provide clinical supervision and case consultation for the ECCs is underway.

Efforts to enhance and expand mental health and dementia treatment for older adults includes the implementation of a pilot project, Caregiver Bridges, which is funded by the AoA Alzheimer's Disease Demonstration Grant to States (ADDGS). Individuals with dementia, or their family caregivers who are experiencing mental health problems are referred to the program by their primary care physician. The Elder Care Clinician provides assessment, counseling and referral services on-site or at the individual's home as desired. On-site dementia training and consultation for partnered primary care physicians, their staff, and other involved community care providers are offered by a geriatric psychiatrist. These interdisciplinary trainings provide an opportunity for participants to share their knowledge with other providers. This pilot project also includes funding to provide statewide dementia training to Elder Care Clinicians and state certified case managers.

The Advisory Council on Elder Mental Health, Dementia and Substance Abuse, which was formed when the ECCP was developed, continues to work in an advisory capacity for the program.

Objectives

1. Expand and enhance services for older adults with mental health issues by developing linkages between primary care physicians, community mental health centers, home health agencies and other community care providers.
2. Support the work of the Vermont Advisory Council on Elder Mental Health, Dementia and Substance Abuse.
3. Continue to support the Governor's Commission on Alzheimer's Disease and Related Disorders.
4. Continue to support Vermont's Coalition on Older Adults and Substance Abuse.
5. Collaborate with the DMH to provide geriatric psychiatry services to clients when required.
6. Collaborate with the DMH to provide training and consultation to ECCs.
7. Continue to provide information to the public about mental health, dementia and substance abuse in order to increase awareness and information about available resources.

Attendant Services Program

The Attendant Services Program (ASP) supports independent living by providing in-home personal care to individuals with disabilities, including both older Vermonters and younger adults. The funding for this program has increased incrementally over recent years, resulting in a State Fiscal Year 2006 budget of $4.5 million. The Legislature added funding for State Fiscal Year 2007 to increase wages by $1.00/hour. Starting in July 2006, the hourly wage for a personal care attendant who has served the same participant for at least 6 months will be $10.00. As of March 2006, the program was serving 255 individuals, 112 of whom were over age 60. The average age of participants was 57 years.

The creation of the Medicaid Participant-Directed Attendant Care Program has improved access for those people who have permanent and severe disabilities, are eligible for Medicaid, and can direct their own care. Those applicants who do not meet these eligibility criteria, however, are likely to wait for a year before funding is available to meet their needs.

Objectives

1. Increase the availability of paid caregivers by working with other stakeholders to bring the ASP salaries for attendants up to date, or more in line with the salaries paid to attendants in other programs who perform similar duties; include medical benefits, and respite for the primary caregiver.
2. Work with stakeholders to continue the forward progress of the ASP to provide a more self-sufficient standard of living for people with multiple disabilities.
3. Eliminate the waiting list for the General Fund Participant-Directed Attendant Care Program or consider revising the program regulations to prioritize applicants based on need rather than date of application. *(Note: The Legislature has directed the Department to conduct a study to "…assess what criteria would be most equitable for placing an individual on the waiting list for attendant care services. In addition to the current first-*

come, first-served basis, the Department shall consider alternative criteria for placing individuals on the waiting list. No later than January 15, 2007, the Department shall submit a report including the criteria considered, its analysis of the issues, and its recommendations for the criteria to be used in the house committee on human services and the senate committee on health and welfare.")

4. Improve the ability of consumers to manage their own services by providing training in consumer-direction skills.
5. Work collaboratively with other DDAS program directors to identify ways to better serve people with disabilities throughout Vermont.

Homemaker, Chore and Personal Care Assistance Services

The Vermont Homemaker Program provides services to older Vermonters and/or adults with disabilities who need assistance to live independently in an environment which is healthy and safe, while contributing to the prevention, delay, or reduction of risk of harm or hospital or other institutional care**.** Services are provided by the local HHAs and include assessment, homemaker services (shopping, housekeeping, errands), and appropriate use of homecare funds (flexible funding).

In State Fiscal Year 2005, a total of $806,221 in General Funds was available through local HHAs to provide assessment, homemaker services and homecare funds to eligible adults. HHAs spent a total of $898,450 (about 11% over-expended). Overall, 95% of all funds were spent on homemaker services, 4% on homecare funds and 1% on individualized assessments.

Approximately 758 individuals (unduplicated) were served by the Homemaker Grant in State Fiscal Year 2005. This is about 100 less (11%) than anticipated. A total of 56,459 hours of service were provided, equally approximately 6 hours per individual per month. This is roughly 2,634 hours less (4.5%) than State Fiscal Year 2004. While there was a reduction of services provided under the State grants, this was likely due to the transfer of State General Funds to be used as match for the creation of Choices for Care program and overall expansion of services through this program in State Fiscal Year 2006.

State Fiscal Year 2006 brought many positive, yet challenging, changes for the Homemaker program, including:

- The creation of a federally matched 1115 waiver program (Choices for Care) to provide homemaker services to the Moderate Needs eligibility group, effective October 1, 2005.
- The addition of General Funds to provide homemaker services in designated Housing and Supportive Services (HASS) sites from July 06-Sept 06 (prior to Choices for Care).
- The reduction of General Funds-supported homemaker Grants to support Choices for Care Moderate Needs homemaker services (starting October 1, 2005).
- By moving some of the General Funds to the Choices for Care Program, approximately $572,195 additional funds available to provide Moderate Needs homemaker Services via the Choices for Care program, starting October 1, 2005.

Residential Alternatives

The Department remains committed to supporting the development of a menu of options that combines housing with supportive services to promote aging in place. To accomplish this objective, several significant system changes have been accomplished since the last State Plan on Aging:

- The Department and the Agency of Human Services has further coordinated reviews with housing funders so that high priority special needs housing projects receive coordinated technical assistance and are more competitive;
- Department staff served on the Housing Needs Assessment Committee that led to greater assessment of general and special needs housing that was reflected in the Consolidated Plan to the U.S. Department of Housing and Urban Development (HUD);
- Assisted living and special needs housing have been maintained as priority needs in the Vermont Consolidated Plan delivered to HUD and in Vermont's Qualified Allocation Plan for Low Income Housing Tax Credits;
- The Department and the AHS worked to increase enrollment by more than 50% in the Medicaid program called Assistive Community Care Services for residential care home and assisted living residents, bringing additional revenue to these providers to help stabilize this needed resource;
- The Department, together with the Vermont Housing Finance Agency and the Office of Vermont Health Access are completing work on the multi-year Robert Wood Johnson Foundation Coming Home grant to make system changes so that developing rural assisted living becomes feasible; and,
- The Department commented on barriers to fair housing in a Fair Housing Impediments evaluation undertaken by the Vermont Human Resource Commission and the U.S. Department of Housing and Urban Development.

Objectives

1. Ensure that the priority housing needs of older Vermonters continue to be appropriately represented in Vermont's Consolidated Plan to HUD and the Qualified Plan for Low Income Housing Tax Credits.
2. Coordinate with ADRCs' efforts to promote consumer education so that consumers are better equipped to select the housing and care alternatives they prefer, and that they have the best potential to support their aging in place or independent living goals.
3. Continue to promote participation in the Housing and Supportive Services (HASS) program, currently operating at 27 congregate housing sites.
4. Continue to support access to VCIL's Home and Community Access Program to help older Vermonters and people with disabilities maintain their independence and remain in their homes by providing technical assistance and funding support for home modifications.
5. Maintain support for existing and replicate match-up shared housing programs, including, where possible, partnering with SHARE to promote these programs.

6. Assist congregate shared housing projects in clarifying and reaching their market niche and making partnerships that promote aging in place for residents; partner with SHARE to promote these programs.
7. Promote a universal design knowledge base in Vermont and explore opportunities to develop a model universally designed home.

Neighbor to Neighbor Program AmeriCorps Program

The Neighbor to Neighbor (N2N) AmeriCorps Program is funded in part by the Corporation for National and Community Service and is administered by the Central Vermont Council on Aging (CVCOA). In addition to operating the N2N program in its four county region, CVCOA has for the past several years, subcontracted program coordination and service delivery to its four sister agencies to extend service delivery statewide. N2N also receives significant General Fund support from the Department ($120,000 annually) and receives additional funding support from the four AAAs, private foundations, donations and in-kind contributions from businesses, organizations and individuals. In 2005, this allowed up to 20 individuals to enroll as members who recruit volunteers and provide services for older adults and people with disabilities across the state. For nine years, N2N has made a difference in the lives of older Vermonters by providing in-home services, successful aging programs, and strengthening intergenerational connections between volunteers and older adults.

Neighbor to Neighbor has a statewide program director and a regional coordinator at each AAA, who in turn, supervise 3 – 5 members serving the AAA area. N2N members make a commitment to 11 months of service, and they receive a living allowance stipend, training and other benefits. During State Fiscal Year 2005, N2N had 20 full-time members, and logged 23,677 service hours.

The mission of N2N AmeriCorps is to serve older Vermonters and people with disabilities by helping them to live independently while aging successfully. Members meet this challenge by building community partnerships that strengthen intergenerational connections and by recruiting adult and youth volunteers who engage with older adults in a variety of ways. Partnerships and volunteers increase program capacity, with the long-term goal that services and programs can be sustained by the volunteers into the future.

N2N services are designed to support individuals as well as providing group-oriented community programs. N2N members and volunteers provide a wide range of direct services , such as helping older Vermonters stack their winter wood supply and winterize their home, assisting in cleaning and organizing living environs that may have become cluttered and potentially dangerous overtime, and making regular visits to assist with shopping and errands. In 2005, these in-home services helped nearly 800 older Vermonters maintain their independence and their ability to continue living at home while strengthening their contacts with community members.

With the growing awareness of the importance of personal life style choices, N2N members offered nearly 250 community-based programs that promote healthy living, physical activity,

nutrition and prevention. Nearly 4,500 older Vermonters and people with disabilities participated in the programs and opportunity to socialize. In Fiscal Year 2006, N2N will have funding to enroll up to 15 members and will have an active presence in four of the five AAA planning and service regions.

Objectives

1. Assist N2N in identifying new ways to extend the services of the AAAs and promote successful aging and independent living in communities in four AAA regions of the state.
2. Provide ongoing financial support to ensure N2N's continued success in Vermont.
3. Use N2N to pilot new initiatives in community-based services, such as *Eden at Home* and *Steps to a Healthy Aging*.
4. Expand the role of community service learning through N2N AmeriCorps as a training opportunity for individuals interested in exploring work options with older Vermonters and people with disabilities.
5. Strengthen collaboration between N2N and senior centers so that older Vermonters and people with disabilities have access to a variety of successful aging strategies.
6. Work with N2N to implement recommendations from quality assurance efforts, building on the program's strengths and adjusting areas needing improvement.

Senior Volunteer and Community Service Programs

The Department has a long-standing commitment to support volunteer and community service opportunities for older Vermonters by providing resources to several volunteer programs that support older Vermonters. We believe older adults benefit from volunteer work and that Vermont's communities are healthier as a result of this involvement. While significant research as well as anecdotal evidence supports the positive aspects of volunteerism, and the Department has always believed in the benefits of volunteerism: older adults who remain engaged and active in their communities will thrive better and stay healthier longer than those who do not. The following volunteer programs receive support through DAIL.

The Vermont Senior Companion Program (SCP) was established in 1981. The Department provides State General Fund support via a contract with the Central Vermont Council on Aging, which works with their local Retired Senior Volunteer Program (RSVP) to administer operations. All five AAAs have SCP grants to ensure that there is a statewide presence through local operations and coordination of services.

SCP's goal is to help older Vermonters remain independent for as long as possible in their own homes. They employ older Vermonters who want to help other older Vermonters and are willing to work up to 20 hours per week as a SCP volunteer. Volunteers must meet income guidelines, be at least 55 years of age, and have desire to serve other older Vermonters. Primary duties include providing peer support, friendly visiting, and simple assistance with daily tasks to older Vermonters who are home bound. In return, they receive a modest stipend, mileage reimbursement, training and team building opportunities and the satisfaction of helping others. In State Fiscal Year 2005, 82 SCP volunteers drove 260,000 miles to provide 68,849 hours of

service to 401 older Vermonters[cxxix]. SCP has faced significant challenges in meeting budget goals due to the high cost of fuel. This unexpected expense has decreased their ability to serve as many people as they would like, and reduced the amount of support they can provide to SCP volunteers.

The Foster Grandparent Programs create opportunities for older Vermonters with low-incomes to serve children and adolescents in their communities. Vermont has two FGPs that provide services in seven counties (Addison, Bennington, Chittenden, Franklin, Grand Isle, Rutland and Washington). Volunteers receive a small stipend and mileage reimbursement, and serve up to 20 hours per week. Foster Grandparents are placed in organizations that serve children, primarily in community settings that are selected and supported by the coordinating agency. During State Fiscal Year 2005 124 FGP volunteers provided 101,764 hours of service to 2,320 children and adolescents.[cxxx]

RSVP operates throughout the State and is administered by three RSVP organizations. RSVP has a long history of offering diverse volunteer opportunities to people 55 years or older. The Department provides funding support to these agencies via General Funds appropriations from the Vermont legislature. Service opportunities range from providing tax preparation assistance to older Vermonters, volunteering for the home delivered meals programs to assisting high school students as tutors and mentors. During State Fiscal Year 2005 2,642 RSVP volunteers provided 370,320 hours of service to 687 community-based organizations.[cxxxi]

Objectives

1. Continue to support and perhaps enhance the Department's role as a funding source that encourages volunteerism for older Vermonters, thus supporting a key concept of successful aging.
2. Maintain collaborative and supportive relationships with the non-profit volunteer agencies committed to supporting volunteerism in Vermont's older population.
3. Examine the stresses placed on these organizations' budgets, which have remained fairly static for the past decade, especially as their capacity to provide service to older Vermonters is diminished due to increased fuel costs.

Senior Community Service Employment Program (SCSEP)

The Department is the recipient of a federal Department of Labor grant that supports training and employment opportunities for Vermonters aged 55 or older. For more than a decade the Department has contracted program administration and operations to a community non-profit, Vermont Associates for Training and Development (VT Associates). Until State Fiscal Year 2005 VT Associates operated statewide, offering services to all income and age eligible older Vermonters, with a special focus on helping people over 60 years of age as well as veterans, minorities and individuals in the greatest economic need. Participants work 20 hours per week, are assessed for skills training needs, and receive a training stipend. SCSEP's primary goal is to help each participant identify their employment goals while learning job skills that will lead to permanent, unsubsidized employment.

In State Fiscal Year 2005, the SCSEP program was transferred from the AoA to the federal Department of Labor. In addition to this change, a new SCSEP player, National Able emerged in Vermont under sponsorship from its lead agency in Chicago, Ill. National Able secured more than $1 million to operate in Vermont and moved its operations into all most every county in the state. The Department's allocation of federal funding fell to $561,352, from more than $1.5 million in the preceding years. Needless to say, these changes created tremendous fall out for the VT Associates program, since the Department had much less funding support to support their operations. In addition to a changing service delivery landscape, new goals and employment targets were implemented. At the same time that VT Associates funding was lowered, their targeted SCSEP enrollment increased from 59 to 68 participants[cxxxii]. These and a number of other administrative requirements have created great challenges and difficulties for SCSEP operations.

During the next several years the SCSEP will face several challenges related to operations. We are reviewing the challenges posed by significantly reduced funding and the impact this has on program effectiveness, while at the same time keeping an eye to the future older worker labor market, which will grow and likely have changing needs over the next decade. The Department expects to play a key role in positioning our state to be prepared as the ranks of older workers swell and will remain alert to and interested in proposed federal changes that would significantly impact older Vermonters who need supportive job training services.

Objectives

1. Develop means to assess the needs and impacts of a changing older worker demographic within the State.
2. Develop strategies to meet the changing needs of older workers.
3. Assess how to best support the SCSEP program operations in Vermont.
4. Determine the extent to which Vermont operations are hindered or helped by having two SCSEP funded programs within the state and take action based on our findings.

SUMMARY OF PUBLIC HEARING AND COMMENT PROCESS

A public hearing via Vermont Interactive Television was held on Monday, June 26 at 3:00 p.m. The following sites were operational: Bennington, Lyndon, Newport, Randolph, Rutland, Springfield, Waterbury and Williston. In addition, written comments to the DRAFT State Plan on Aging for Federal Fiscal Years 2007 – 2010 were accepted **until no later than 4:00 p.m. on Monday, July 3, 2006**. With the exception of three Department staff, no individuals attended the public hearing to offer comments. However, in addition to input received from Department staff, written comments were received from: representatives of two senior centers, an adult day program executive director, an Area Agency on Aging Executive Director, and the Statewide Program Director for the Neighbor to Neighbor AmeriCorps Program.

Representatives of the senior centers commented on the lack of the distinction between senior centers and multi-purpose senior centers, on the challenges facing Vermont's senior centers and community meal sites, including the decline in participation in community meal programs, and on their on-going concern about gaps in funding to support the work or foster the development of senior centers. A general definition of multi-purpose senior center has been included in the FINAL DRAFT State Plan on Aging, and further clarification on the sources of funding for senior centers and community meal programs has been included. In addition, one writer encouraged the state to change the name "senior center" to "community center" in order to appeal to a broader group of individuals and change the identify of senior centers as a place "only for old folks." In fact, through the senior center federal funding received, some programs across the state are looking at this issue as a community issue.

The adult day program executive director offered a number of technical comments to the State Plan on Aging to clarify or correct information, and appropriate changes have been made, particularly related to the current economic times in Vermont and nationally and inclusion of adult day programs as partners specifically with the Alzheimer's Disease Demonstration Grant. The writer also posed a number of questions that, while they did not require changes to the FINAL DRAFT State Plan on Aging, follow up will occur and responses to the questions provided to the writer, as well as to the membership of the Vermont Association of Adult Day Services, as they were copied on this correspondence.

The AAA Executive Director suggested inclusion of a clear reference to the idea of helping communities to plan for the needs of an aging population, and this has been incorporated into the FINAL DRAFT State Plan on Aging. The writer also suggested inclusion of additional housing and residential alternatives work that is underway in Vermont, and the specific programs and initiatives are now included in the final draft. In addition, mention of the growth of Tufts Strong Living and Bone Builders has been included in the final draft, in response to additional comments from this writer.

Finally, the Neighbor to Neighbor AmeriCorps Statewide Program Director commented on the placement of N2N program information within the State Plan on Aging, and offered some suggested changes to information and objectives for the program. Many of the suggested changes clarify emphasis of the program and have been incorporated into the Final Draft State Plan on Aging.

METHOD OF DISTRIBUTION FOR TITLE III AND STATE FUNDING

There are four steps in the distribution process of Older Americans Act and state funding to the Area Agencies on Aging. These include:

1. Base distribution of $425,220 is divided equally among the AAA ($85,044 per AAA).
2. Calculation of remaining funds includes weighting of factors related to social need (OAP), numbers of aged 60 and over and economic need.
    - One-third of the funds are distributed according to age;
    - 80% of the remaining two-thirds is distributed using the OAP formula;
    - 20% of the remaining two-thirds is distributed according to the number of individuals below 125% of poverty.
3. Social need calculation based on population cohort age 75+ living alone and below the poverty line (OAP) in each AAA region.
4. Economic need based on population cohort 60+ below 125% of poverty and not OAP (Pov 125) in each AAA region.

Funding Formula Factors

Population cohorts for cohorts for the 60 and Over Age category are based on the Municipal Population Estimates for July 1, 2000 through July 1, 2004 as published by the US Census in conjunction with the Federal/State Cooperative Program for Population Estimates (FSCPE) and use 2000 Census baseline data.

Population cohorts for the Old, Alone and Poor category (OAP) are estimated based on detailed economic and demographic data from the 2000 Census. Specifically, the 2000 Census data for Old, Alone and Poor are projected forward based on the percentage growth rate by age segments in the Age 75 and Over cohort between the July 1, 2000 Census and the July 1, 2004 Census estimates.

Population cohorts for the Pov125 category are estimated based on detailed economic and demographic data from the 2000 Census. Specifically, the 2000 Census data for Pov125 are projected forward based on the percentage growth in the Age 60 and Over cohort between the 2000 Census and the 2004 Census estimates by County and Region.

POPULATION DATA AND 'OLD, ALONE AND POOR'
DATA FOR SELECTED AAA SERVICE AREA by ELDERLY AGE GROUPS

These are the age 60 and over factors (Age):

Area	Population	Factor (% of State)
Central	19,837	19.13%
Champlain	32,484	33.13%
Northeast	12,170	11.74%
Southeast	19,479	18.79%
Southwest	19,717	19.02%
Total	103,687	100%

These are the Old, Alone and Poor Factors (OAP):

Area	Population	Factor (% of State)
Central	477	20.18%
Champlain	662	28.00%
Northeast	369	15.61%
Southeast	394	16.67%
Southwest	462	19.54%
Total	2,364	100%

These are the age 60 and over, below 125% of Poverty, not the OAP Factors (Pov 125%)

Area	Population	Factor (% of State)
Central	1,896	18.41%
Champlain	2,859	27.75%
Northeast	1,770	17.18%
Southeast	1,782	17.30%
Southwest	1,994	19.36%
Total	10,301	100%

Note: *Population cohorts for the 60 and Over Age category are based on the Municipal Population Estimates for July 1, 2000 through July 1, 2004 as published by the US Census in conjunction with the Federal/State Cooperative Program for Population Estimates (FSCPE) and use 2000 Census baseline data. Population cohorts for the Old, Alone and Poor category (OAP) are estimated based on detailed economic and demographic data from the 2000 Census. Specifically, the 2000 Census data for Old, Alone and Poor are projected forward based on the percentage growth rate by age segments in the Age 75 and Over cohort between the July 1, 2000 Census and the July 1, 2004 Census estimates.*

OLDER AMERICANS ACT ALLOCATIONS TO AREA AGENCIES ON AGING

RESOURCE PROJECTIONS FOR 2007 BASED ON AWARD DATED 02/06/2006

	CENTRAL	CHAMPLAIN	NORTHEAST	SOUTHEAST	SOUTHWEST	TOTAL
TITLE III AND VII	85,044	85,044	85,044	85,044	85,044	425,220
SERVICE BASE	760,709	1,129,010	564,076	677,807	750,996	3,882,598
SUPPORTIVE SERVICES						
SUB-TOTAL SERVICES	845,753	1,214,054	649,120	762,852	836,041	4,307,820
AREA PLAN ADMINISTRATION	100,132	100,134	100,133	100,133	100,132	500,662
NET TITLE III AND VI	945,885	1,314,186	749,253	862,985	936,173	4,808,482
STATE GENERAL FUND	557,493	827,408	413,390	496,740	550,376	2,845,408
STATE TRANS. FUND(included in GF now)	0	0	0	0	0	0
SPECIAL SERVICES FUND	4,771	6,622	3,691	3,941	4,621	23,646
LIHEAP (ENERGY)	15,000	15,000	15,000	15,000	15,000	75,000
FOOD STAMP OUTREACH	41,634	61,792	30,872	37,097	41,105	212,500
MEDICAID ADMIN (ELIGIBILITY)	29,389	43,618	21,793	26,186	29,014	150,000
ALZHEIMER FUND	85,356	139,774	52,366	83,815	84,839	446,150
ST GEN FUND TRANS TO DMH	48,982	72,697	36,321	43,643	48,357	250,000
NSIP	105,576	160,007	78,463	127,135	125,681	596,862
TOTAL	1,834,087	2,641,104	1,401,149	1,696,542	1,835,166	9,408,046

Title III and VII funds are based upon the February 6, 2006 Title III and VII FY06 awards to the State.
Food Stamp Outreach allocation is based on FY06 agreement with the Department for Children and Families. AAA allocations are based upon the IFF Funding Formula.
Title III and related resources are based on 2000 Census data and July 1, 2004 Census estimates for Vermont by county and age.
Old Alone and Poor, Pov 125 and 60+ population figures are based on Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data
Nutrition Services Incentive Program (NSIP) uses FY04 award and is allocated using total meals served for FY05.

AAA FEDERAL FISCAL
YEAR07 Allocation

		Total	Central	Champlain	North East	South East	South West	Total
Area Plan Administration		500,662	100,132	100,132	100,133	100,133	100,132	500,662
service base		425,220	85,044	85,044	85,044	85,044	85,044	425,220
Age		1,294,199	247,601	405,458	151,903	243,133	246,103	1,294,198
OAP		2,070,718	417,823	579,871	323,221	345,119	404,683	2,070,717
POV125		517,683	95,285	143,681	88,952	89,555	100,210	517,683
Total Title III		4,808,482	945,885	1,314,186	749,253	862,984	936,172	4,808,480
Title VII		0.00530	5,011	6,962	3,968	4,572	4,959	25,472
Title III-D		0.02203	20,837	28,950	16,506	19,011	20,624	105,929
Title III-B		0.31441	297,395	413,192	235,573	271,330	294,341	1,511,828
Title III-C1		0.39666	375,194	521,284	297,199	342,311	371,341	1,907,328
Title III-C2		0.18726	177,125	246,092	140,304	161,601	175,306	900,428
Title III-E		0.74350	70,324	97,705	55,704	64,160	69,601	357,494
	Total	1.00000	945,886	1,314,185	749,254	862,985	936,172	4,808,479
GENERAL FUNDS			557,493	827,408	413,391	496,741	550,377	2,845,410
MENTAL HEALTH			48,982	72,697	36,321	43,643	48,356	249,999
			606,475	900,105	449,712	540,384	598,732	3,095,408

VERMONT

State Agency on Aging

Department of Disabilities, Aging and Independent Living
103 South Main Street
Waterbury, Vermont 05671-1601
Commissioner: Patrick Flood
Phone: (802) 241-2401
Fax: (802)
TTY: (802) 241-3557
State Unit on Aging Contact: Camille George
Phone: (802) 241-2427
Fax: (802) 241 - 4224
Website: www.dail.state.vt.us

Area Agencies on Aging

Statewide Information and Assistance: Senior HelpLine: 1-800-642-5119

Central Vermont Council on Aging
30 Washington Street
Barre, VT 05641
Director: Elizabeth Stern
Phone: (802) 479-0531
Fax: (802) 479-4235

Champlain Valley Agency on Aging
P.O. Box 158
Winooski, VT 05404
Director: John Barbour
Phone: (802) 865-0360
Fax: (802) 865-0363
Web site: www.cvaa.org
E-mail: info@cvaa.org

Council on Aging for Southeastern Vermont
56 Main Street, Suite 304
Springfield, VT 05156
Director: Joyce Lemire
Phone: (802) 885-2655
Fax: (802) 885-2665
Web site: www.coasevt.org

Northeastern VT Area Agency on Aging
1161 Portland Street
St. Johnsbury, VT 05819
Director: Ken Gordon
Phone: (802) 748-5182
Fax: (802) 748-6622
Web site: www.nevaaa.org

Southwestern Vermont Council on Aging
East Ridge Professional Building
1085 U.S. Route 4 East, Unit 2B
Rutland, VT 05701
Director: Diane Novak
Phone: (802) 786-5990
Fax: (802) 786-5994
Web site: www.svcoa.org

OLDER AMERICANS ACT, AS AMENDED IN 2000

STATE PLAN ASSURANCES AND PROVISIONS

Sec. 305, ORGANIZATION

(1) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area. ((a)(2)(A))

(2) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan. ((a)(2)(B))

(3) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low income minority individuals and older individuals residing in rural areas and include proposed methods of carrying out the preference in the State plan. ((a)(2)(E))

(4) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16). ((a)(2)(F))

(5) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low income minority older individuals and older individuals residing in rural areas. ((a)(2)(G)(ii))

(6) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. ((c)(5))

Sec. 306, AREA PLANS

(1) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services

(A) services associated with access to services (transportation, outreach, information and assistance, and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded. ((a)(2))

(2) Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan. ((a)(4)(A)(i))

(3) Each area agency on aging shall provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will

(A) specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in the area served by the provider;

(B) to the maximum extent feasible, provide services to low-income minority individuals and older individuals residing in rural areas in accordance with their need for such services; and

(C) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals and older individuals residing in rural areas within the planning and service area. ((a)(4)(A)(ii))

(4) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall

(A) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(B) describe the methods used to satisfy the service needs of such minority older individuals; and

(C) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i). ((a)(4)(A)(iii))

(5) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

(E) older individuals with limited English-speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals);

and inform the older individuals referred to in (A) through (F), and the caretakers of such individuals, of the availability of such assistance. ((a)(4)(B))

(6) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas. ((a)(4)(C))

(7) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities. ((a)(5))

(8) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title. ((a)(9))

(9) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans. ((a)(11))

(10) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships. ((a)(13)(A))

(11) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency

(A) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(B) the nature of such contract or such relationship. ((a)(13)(B))

(12) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships. ((a)(13)(C))

(13) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships. ((a)(13)(D))

(14) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals. ((a)(13)(E))

(15) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title. ((a)(14))

(16) Each area agency on aging shall provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title. ((a)(15))

Sec. 307, STATE PLANS

(1) The plan describes the methods used to meet the need for services to older persons residing in rural areas in the fiscal year preceding the first year to which this plan applies. The description is found on page(s) 8 and 50 - 77 of this plan. ((a)(3)(B)(iii))

(2) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract. ((a)(7)(A))

(3) The plan shall provide assurances that-

> (A) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
>
> (B) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
>
> (C) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act. ((a)(7)(B))

(4) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000. ((a)(9))

(5) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs. ((a)(10))

(6) The plan shall provide assurances that area agencies on aging will--

> (A) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
>
> (B) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(C) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis. ((a)(11)(A))

(7) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services. ((a)(11)(B))

(8) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; ((a)(11)(D))

(9) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. ((a)(11)(E))

(10) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for-

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate. ((a)(12))

(11) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State. ((a)(13))

(12) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.
((a)(14))

(13) The plan shall provide assurances that the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

(E) older individuals with limited English-speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses (A) through (F) and the caretakers of such individuals, of the availability of such assistance. ((a)(16))

(14) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities. ((a)(17))

(15) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them. ((a)(18))

(16) The plan shall include the assurances and description required by section 705(a). ((a)(19))

(17) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services. ((a)(20))

(18) The plan shall-

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities. ((a)(21))

(19) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8). ((a)(22))

(20) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs. ((a)(23))

(21) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance. ((a)(24))

(22) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title. ((a)(25))

(23) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title. ((a)(26))

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(1) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph. ((b)(3)(E))

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except

(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

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